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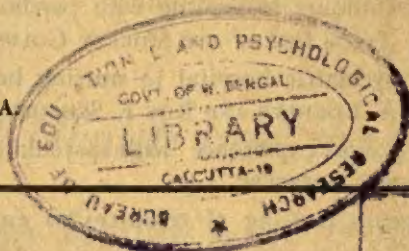
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Saleem A. Shah, Ph.D.

Community Mental Health and the Criminal Justice System: Some Issues and Problems

The author discusses problems raised in the handling of social deviance by the community mental health and criminal justice systems. He points out that while different labels, such as "sick", or "mentally disordered" may be applied to an offender, society's response, under the guise of "treatment" is often no different from incarceration without the legal safeguards afforded "sane" prisoners. He argues that many of the traditional mental health concepts are inadequate in the community mental health setting. More emphasis should be placed on environmental manipulation. Mental health professionals need to re-examine their thinking in relation to traditional diagnostic techniques, community based treatment for offenders, legal safeguards in civil commitment and ability to predict dangerous behavior.

This presentation will focus on a few of the important issues, problems, and challenges pertaining to the handling of social deviance by the community mental health and criminal justice systems. Since both systems are very much concerned with the definition, labeling, and handling of a wide range of social deviance, numerous points of interaction and collaboration are inevitable. Some outstanding problems with traditional mental health concepts and practices will be noted, a few community

mental health principles and approaches will briefly be outlined, and some specific points of interaction will be discussed.

Historically the basic objectives of mental health and the criminal justice system have become intertwined. While previously the mentally ill were regarded and treated much like criminals, at the present time an increasingly wide range of deviants defined as criminals are being regarded by many as suffering from mental disease or illness.⁸⁴

This article is a condensed version of a paper delivered at the Seminar on Law and Community Mental Health held in Zion, Ill. June 11-13, 1969. It was sponsored by the NIMH, the Illinois Department of Mental Health and the University of Illinois.

Dr. Shah is Chief of the Center for Studies of Crime and Delinquency of the National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Md. 20015.

The evaluation of criminal behavior as reflecting mental illness appears often to be predicated, at least in part, on a desire to provide more humane and therapeutic handling for such persons. Many commentators have noted, however, that the benign aims and remedial intentions have not often been followed by consequences which could be judged as therapeutic and humane.^{3, 7, 9, 11, 15, 17, 27, and 32}

More humane treatment in the handling of deviants has generated certain problems involving a gradual confusing and confounding of the "social control" or deterrent functions and objectives of the criminal law with the "therapeutic" and remedial objectives of mental health.

This mixture of social control with mental health and social welfare objectives and ideologies appears to have been a significant factor in the development of the philosophy and procedures of the juvenile court, especially within the United States.

The legal proceedings were defined as "civil" rather than "criminal," and instead of criminal convictions the judicial findings led to status adjudications.

The stated "therapeutic and remedial" intentions may, in fact, be designed in large measure to avoid the Constitutional prohibitions against preventive detention.

Within the past three decades certain other categories of adult offenders have also been viewed as requiring "remedial" and "therapeutic" handling instead of regular criminal sanctions. Thus, varieties of offenders, mainly sex offenders, have been

covered by special statutes aimed at persons designated as "sexual psychopaths", "sexually dangerous persons", and the like. Here again, legal proceedings have been designated as "civil" rather than "criminal", and status adjudications have replaced criminal convictions. The particular concepts and labels that are applied tend to determine the manner in which the person will be handled. Thus, if we were to consider the rules defining the intended meaning of certain labels, juvenile delinquents are not supposed to be "punished" but "treated". Their involuntary confinement does not constitute "incarceration", but is believed to be "residential care and treatment". Likewise, "sexual psychopaths" are so designated in order that they may receive "remedial", "curative", and other "therapeutic" services. Hence, even though they may end up with long and indeterminate confinement in marked contrast to the more limited penal sanctions allowed by criminal statutes, such handling is not supposed to be construed as "punitive" since the stated aims are therapeutic and the red brick buildings in which such persons are confined are often referred to as "hospitals". As we all are supposed to know, "hospitals" provide "treatment" while prisons provide "punishment". Finally, since such proceedings have been clearly labeled as "civil" in those instances where the individual is later subjected to "criminal" prosecution for the same deviant behavior even after his apparent recovery in the "remedial" institution, such actions cannot be construed to violate the constitutional prohibitions against double jeopardy.

These are some of the "word games" which result from the confusion of social control and therapeutic objectives in the handling of certain types of social deviants.

Despite the professed good intentions and

idealistic rhetoric which typify "civil" procedures of the kind described, in view of the actual consequences that individuals subjected to such procedures experience, there is reason to believe that the societal motives involved have been and continue to be less than wholly benign and therapeutic. The stated "therapeutic and remedial" intentions may, in fact be designed in large measure to avoid the Constitutional prohibitions against preventive detention.

Some Traditional Mental Health Concepts and their Limitations

Mental health professionals typically come from a background of clinical training and experience. When these professionals work in community mental health settings a number of weaknesses become apparent in the clinical concepts and intervention strategies commonly utilized.

Three major weaknesses which have been noted in traditional mental health concepts²³ will be discussed briefly.

1. Behavior has traditionally been viewed largely as a function of the individual's inner or "intrapsychic" life. The treatment approaches derived from this conceptualization have typically involved the one-to-one therapeutic interaction. And, since such treatment is largely mediated through verbal communications, the ability to talk about oneself and one's feelings, to form verbal abstractions, and to introspect, were necessary for such therapy suitably to be conducted. Thus, not only have social class variables been involved in the practice of psychotherapy as demonstrated by Hollingshead and Redlich¹⁸, but it has been suggested that many of the basic concepts and principles of traditional psychotherapy tend to be class-linked.²⁵ and ²⁴ These therapeutic techniques are not very applicable with lower class persons, a category which

encompasses the bulk of convicted offenders. Given the available evidence for the effectiveness of psychotherapy and the manpower situation in regard to mental health professionals, such one-to-one therapeutic interventions are extremely costly in addition to being very inefficient.

2. A second conceptual weakness of traditional mental health approaches is the tendency to psychologize a variety of social problems, i.e., the tendency to assign psychological causes to such phenomena. We hear talk, for example, about "sick communities", "castrated people", "pathological families", and "sick societies"—all of which adds little or nothing to our understanding of the complexities of a community, a social system, or the socio-political struggles involved in social movements.

Moreover, by applying psychodynamic and mental health terms and concepts, the impression may be given that we really understand the phenomena, that psychodynamic concepts are relevant and applicable, and that we can also somehow pinpoint the necessary "therapy" for such societal ills.

3. Perhaps the most important conceptual weakness relates to the illness model borrowed from clinical medicine. There has been much discussion of the problems associated with the concept of "mental illness".^{23, 28} and ²⁴

It is the psychiatric or mental health model of illness which has inherent in it many conceptual weaknesses. The major problem results from the tendency to view deviant behavior as abnormal, and then to consider such deviations from the norm as indicative of psychopathology or illness.

Medicine approaches the notion of abnormality in line with the dictionary meaning of the term, viz., "not average, typical, or usual, deviating from a standard, ex-

tremely or excessively large." In medicine, abnormality is not necessarily associated with illness. A seven foot basketball player may reflect abnormal growth, but he is not thereby considered ill. It could be, however, that certain abnormalities may be the result of pathology, while other abnormalities may increase the likelihood of one's becoming ill even though they are not pathological in themselves.

In mental health, however, the notion of illness has been used to describe (label) and also to "explain" a veritable host of deviant and disturbing behaviors, e.g., crime, delinquency, promiscuity, marital infidelity, racial prejudices, political fanaticism, general unhappiness and discontent, sometimes even the behavior of those whom we happen not to like, and also those who do not fit into the prevailing togetherness that we may like to think characterizes middle-class American life.

Essentially, the difficulty with the psychiatric or mental health concept of illness has to do with the confusion resulting from the rough formula: behavioral deviancy=abnormality=mental illness. It could be that clinicians tend to have an occupationally trained incapacity to look at problems of

Our society defines a very wide range of problems as the concern of the juvenile and criminal justice systems. Yet, in terms of volume, most of the cases in the criminal courts involve essentially violations of moral norms or instances of annoying behavior, rather than dangerous crime.

the individual in terms of the broader and non-pathological social context.

Some Concepts Related to Community Mental Health

Reiff²⁸ has suggested three ideas as basic to the concept of community psychology which are closely related to the concept of community mental health. The three ideas are the following: major emphasis is placed upon social system intervention to bring about changes in individual behavior; the social interventions should go beyond the clinical case or the individual toward influencing in some degree the behavior of all people in the sub-system or system; as opposed to the notion of the therapist working with particular disturbed individuals, the community mental health worker is expected to assume the role of a participant-conceptualizer. The term "participant-conceptualizer" stresses the activist component in professional life and indicates the active and close involvement of the mental health professional with various social systems influencing the behavior of troubled or troublesome individuals.

Obviously, the state of our present knowledge about complex social systems and available intervention strategies finds us at some distance from the above community mental health objectives. Quite obviously, too, community mental health professionals need greatly to broaden their knowledge through studies in the fields of sociology, anthropology, ecology, political science, politics, law, community planning, and all forms of social action.

The Concept of Social Competence

Related to the aforementioned developments in community mental health, the notion of social competence has also been

gaining attention as a more viable and less problematic concept than that of mental illness.^{10 and 22} Social competence has been viewed as developing along three major dimensions, all closely interrelated.

First is the ability to learn or to use a variety of alternative pathways or behavioral responses in order to reach a given goal. Second, the socially competent individual comprehends and is able to use a variety of social systems within the society, moving within these systems and utilizing the resources they offer. Third, social competence depends upon effective reality testing. Reality testing involves not merely the lack of psychopathological impairment in perception of the world, but also a positive, broad and sophisticated understanding of this world.

Intervention approaches based upon a social competence model follow the premises that: 1. The psychologically or socially inadequate person needs to learn success-oriented ways of behaving in society, in addition to alleviation of his anxieties and correction of maladaptive behaviors; 2. With growing competence and social achievement an individual also grows in general psychological strength—which can enable him to then cope with formerly serious emotional problems; 3. Social competence will most effectively be achieved when intervention is directed at the level of the ecological unit—consisting of the individual and his immediate and relevant social environment; and 4. The ecological unit can have a range of definition from the very narrow immediate context of treatment to the breadth of an entire community. However, throughout the intervention process one must be concerned both with the individual's competence and also with the design of social pathways through which he will travel and in which he will learn additional personal and social skills.¹⁰

A Behavioral Conceptualization and Model

In contrast to the "intrapsychic" conceptualization discussed earlier, in which behavior is viewed as largely a function of the individual's inner or mental life, a behavioral conceptualization has a different emphasis. Behavior is viewed and defined as involving an interaction between an individual and a particular environment. For example, one does not behave on the job as he does in church, the New Year's party, the poker game, or in the privacy of the home. Biochemical factors relating to the consumption of alcohol or other drugs can also markedly alter and influence behavior. To varying degrees the environment influences and controls the kind of behavior displayed. It is not surprising, therefore, that offenders described as highly impulsive, explosive, and dangerous while in the community, may later be described as "model inmates" within correctional institutions.

Since behavior is viewed as representing an interaction between the individual and a particular environment, emphasis is placed upon understanding the factors which currently maintain and influence the relevant behavior. Much attention is given toward influencing the physical and social environment in order to facilitate and bring about changes in the behavior of the individual.

The above conceptualization is most relevant in the assessment of behavior. A person's functioning is inadequate or deficient in reference to some specific task or situation. Inadequacy of behavior relates both to the available skills (repertoires) possessed by the person, and also to the complexity of the situation (environment) in which he has to function. For example, a young man who may be described as lazy, shiftless, lack

ing in interest, and with a low tolerance for frustration, may in some other situations display remarkable patience, interest, persistence, and ingenuity; e.g., when working on his hot rod, training as an athlete, courting a girl, or planning a heist.

In regard to predictions, clinicians tend mainly to consider the characteristics of the individual in assessing future behavior. Sufficient attention is generally not given to the particular settings, situations, and environments which will interact in different ways with the individual variables. Thus, certain social settings and environments may tend to inhibit, suppress, and control deviant behavior, while others might encourage, elicit, and even provoke such behavior.^{25, 26}

Some Specific Issues and Community Mental Health Contributions

Societal definition and handling of deviance. Our society defines a very wide range of problems as the concern of the juvenile and criminal justice systems. Yet, in terms of volume, most of the cases in the criminal courts involve essentially violations of moral norms or instances of annoying behavior, rather than dangerous crime. Almost half of all arrests are on the charges of drunkenness, disorderly conduct, vagrancy, gambling, and minor sexual violations.²³ Moreover, the President's Crime Commission has pointed out that a major factor in the predicament faced by the criminal system involves the too ready acceptance of the notion that the way to deal with almost any kind of reprehensible conduct is to make it a crime.²³ As Morris and Hawkins,²⁰ among many others,^{1, 23} have pointed out, this "overreach" of the criminal law is extremely costly—in terms of the harm that is done and the secondary deviance that is generated; also in terms of the neglect of the proper tasks of law enforce-

ment and more effective utilization of the criminal law.

To decrease the number of deviants funneled into the juvenile and criminal justice systems, efforts need to be directed at influencing societal tolerance and labeling so that non-dysfunctional deviant behavior might better be tolerated, the range of deviances defined as delinquency and crime be reduced, and other alternate community programs and facilities developed to address these social problems.

Another critical need in this regard pertains to the development of appropriate consultative and training services to law enforcement officers and prosecutors, i.e., persons who are key "gatekeepers" to the criminal justice system. A rather critical function of community mental health agencies should be to provide these "gatekeepers" with reliable and accurate information to assist them in their decision-making functions. A variety of research needs is glaringly apparent. A number of other programs can also be developed with law enforcement agencies to assist them in various aspects of their activities.

Diversion from the criminal justice system. Another way of decreasing the load on the criminal justice system is to screen out and divert to other social institutions and agencies deviants who might more appropriately be handled in other systems. For example, it has been suggested that persons accused of crime and found to be suffering from emotional and related problems, could be screened and diverted, at the pre-trial or even pre-charge stage, to appropriate treatment and rehabilitative agencies.^{27, 28}

Based on some detailed recommendations to the President's Crime Commission on this subject,²⁷ a pilot project supported by NIMH is currently undertaking a program to develop and carefully evaluate the pre-

trial diversion of mentally disturbed persons from the criminal process.

Mental health diagnostic and predictive procedures. In various community programs as well as in correctional institutions, a good deal of the time and effort of mental health professionals is taken up with diagnostic evaluations. Often little time is left for providing other and more useful mental health services. One might question whether the traditional test battery, or mental status evaluations, or detailed social histories which may go as far back as to describe the erotic interests of the patient's grandparents, are very relevant to the intervention strategies needed within a community mental health framework. In view of the recurring commonalities in the life histories and clinical pictures obtained from many chronic offenders, one might as easily diagnose them as suffering from "low incomism, superimposed on cultural deprivation, chronic undifferentiated type".

The above comments reflect serious concerns about the use of scarce mental health professionals to provide traditional diagnostic studies, especially when the reliability, validity and general efficiency of such efforts remains relatively undetermined. However, the impression among many persons in the criminal justice field seems to be that assessments provided by psychiatric and mental health professionals are in some way akin to pronouncements by the proverbial Greek oracles. An increasing number of difficult decisional problems, e.g., determinations pertaining to release on bail or on recognizance, are seen by some persons to require psychiatric and mental health assessments, even though the relevance and demonstrated reliability and predictive validity of such evaluations remains to be determined.

Community-based treatment and rehabilitative programs. It has frequently been

stated that large numbers of confined offenders and delinquents could quite satisfactorily be treated and supervised in the community. It is noteworthy that along with having one of the most moralistic criminal laws in the Western world, the United States also stands very high in reference to the frequency and severity of penal confinement.

While there has been much movement toward diversified programs of community corrections, the need for carefully developed and systematically evaluated programs is still great. A program which shows much

It would appear that the poor motivation of offenders for treatment is further compounded by the equally poor motivation of many mental health professionals to get involved with these difficult cases.

promise in this regard is California's Community Treatment Project (CTP), partially supported by NIMH.²¹ Based at least in part on the results of the CTP, in 1966 California launched a rather unique Probation Subsidy Program designed to markedly increase community supervision and handling of convicted youth offenders.^{30 and 31} Simply stated, the plan encourages counties to reduce their rates of commitment to state correctional institutions in return for a subsidy (up to \$4000 for each uncommitted case) which is commensurate with the overall degree of reduction achieved. Consistent with a state-approved plan, the subsidy (derived from savings by the state for cases previously cared for by the state) has to be used by the counties to improve and expand

probation supervision and other community facilities for delinquents and offenders.

Among other promising innovations in community corrections is the increasing use of support-professionals and non-professionals (including ex-offenders) to provide a variety of services. For example, the Probation Case-Aides Project in Chicago, being supported in part by NIMH, is utilizing carefully selected indigenous non-professionals (including some ex-offenders) in the supervision of probationers. Many other programs are utilizing citizen volunteers to assist in probation supervision and also to get more directly and meaningfully involved in addressing the delinquency and crime problems of their community. A good example of such a program is the one being conducted by Judge Keith Leenhouts in Royal Oaks, Michigan.¹⁸

To date, mental health agencies have not exactly distinguished themselves by their eagerness to provide treatment and related services for offenders. It would appear that the poor motivation of offenders for treatment is further compounded by the equally poor motivation of many mental health professionals to get involved with these difficult cases.

Some issues pertaining to law and mental health. Previous remarks have already pointed to some of the undesirable consequences resulting from confusion of social control and therapeutic objectives in the handling of law violators who are also believed to be suffering from mental disorders. There are a number of other situations and legal procedures in which similar problems arise. It has been only during the past two or three years that a number of landmark Supreme Court and appellate decisions have required greater attention to "due process" and other safeguards in civil commitment procedures; these decisions have also addressed the issue of "right to treatment"

when persons are involuntarily confined supposedly for purposes of treatment.*

A study of psychiatric examinations in connection with civil commitment proceedings found that the psychiatric interviews ranged in length from 5 to 17 minutes, with a mean time of 10.2 minutes. Despite the perfunctory nature of the examinations, the examiners appeared to make the presumption that mental illness was present and usually recommended commitment. These recommendations were very speedily rubber-stamped by judges—the mean time observed in one court was 1.6 minutes!²⁴ A number of studies have also suggested that mental health examiners often confuse legal issues with mental health issues, confuse different legal issues such as fitness to plead and criminal responsibility, and tend to use irrelevant and unnecessarily strict criteria in recommending release from the hospital.

One also finds that with striking regularity questions and issues that are basically and clearly legal come to be re-defined or are interpreted within mental health terms and concepts. For example, the legal determination of incompetency to stand trial somehow becomes synonymous with medical and psychiatric criteria justifying automatic commitment to a mental hospital. Similarly, an adjudication of not guilty by reason of insanity—basically and essentially a moral and social value judgment—often leads automatically to involuntary and indeterminate commitment to a hospital; this without a specific finding as to the current need for such confinement.

* For example: *Baxstrom v. Herold*, 383 U.S. 107 (Feb. 23, 1966), *Rouse v. Cameron*, 125 U.S. App. D.C. 366, 373 F 2d 657 (1966), *Lake v. Cameron*, 124 U.S. App. D.C. 264, 364 F 2d 657 (1966), *Millard v. Cameron*, 125 U.S. App. D.C. 383, 373 F 2d 486 (1966), *Nason v. Supt. of Bridgewater State Hosp.*, 233 N.E. 2d 908 (Mass. 1968).

In both of the above situations it is difficult to understand why outpatient examinations and community based treatment could not be used in a number of situations. In a noteworthy decision in the District of Columbia,* the court upheld the defendant's argument that inpatient commitment for mental examination violated his right to pre-trial bail under the Bail Reform Act. The court also held that if a defendant so requests, his commitment shall be limited

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to examination on an outpatient basis, unless hospital authorities set forth reasonable grounds for believing that inpatient commitment is necessary for an effective examination.

Studies such as the NIMH supported research currently being conducted by McGarry and Lipsitt on the issue of pre-trial incompetency, offer much hope that the criteria for such determinations can be made more precise and objective. It appears on the basis of initial findings that, given careful and relevant examinations and with the close involvement of legal con-

sultants, a much smaller number of persons would properly be found incompetent to stand trial. Lacking adequate examinations by mental health professionals who have a clear and accurate understanding of the legal questions and criteria involved, thousands of persons found incompetent to stand trial spend many years on the back wards of state hospitals across the country. It should be remembered, of course, that these accused persons are presumed to be innocent and that they have not had their day in court. Furthermore, often the offenses involve misdemeanors which upon conviction would bring sentences of less than a year.

There is a great need to develop training programs for lawyers and mental health professionals in order that they might be more alert to some of the problems and dangers in the above situations, be better informed about legal and mental health issues, and thus function more effectively. It is also most essential to provide community based programs for mental examinations and also treatment for the categories of persons discussed above.

Another serious problem is that of trying to assess and predict "dangerousness". It is quite common to find mental health professionals making predictions as to the future dangerousness of an individual. What is very hard to find, however, are systematic evaluative studies to determine the accuracy of predictions which lead to preventive incarceration. The follow-up study by Hunt and Wiley¹⁴ of cases released following the Baxstrom decision,* revealed that clinicians typically tend to over-predict the likelihood of dangerous behavior. Other writers on this subject^{7, 17, 28} have also noted the limited accuracy of the aforementioned predictions, as well as the great

* *Marcy v. Harris*, 400 F 2d 722, U.S. Ct. App. D.C., 1968.

* *Baxstrom v. Herold*, 383 U.S. 107 (Feb. 23, 1966).

technical difficulties in predicting low frequency events.

Finally, it is most important to note the critical value of key legal decisions which can bring about vast and nation-wide changes in institutional practices. As compared to the relatively limited range of efforts directed at particular individuals or facilities, landmark decisions can influence the handling of thousands of persons across the country. For example, in New York State alone the Baxstrom decision led to 969 persons being removed from security hospitals to civil hospitals and released to the community.

Mental health professionals need to work closely with lawyers to develop test cases which could lead to important and far reaching improvements in the handling of mentally disturbed persons and those accused or convicted of crimes. Likewise, legislative means also need to be used to bring about changes and improvements in larger social systems.

Conclusions

This presentation has indicated some of the problems with traditional clinical concepts in mental health practice, especially in relation to various interactions with the criminal justice system. A variety of alternate concepts and approaches have been mentioned which relate to community mental health programs. It should be emphasized that, while the concepts and principles are fairly clear, mental health professionals have a long way to go in order to acquire the necessary knowledge and expertise about the community, various social systems, the socio-political power structures, and other skills relevant to the effective utilization of community mental health intervention strategies.

Those of us in the mental health field

need to be alert that we do not become prematurely enamored of new concepts and slogans, while ignoring or under-emphasizing the careful development of sound programs. There is also the danger that new programs may tend to become institutionalized before an adequate knowledge base has been developed and the value of such programs has systematically been demonstrated.

Following their very detailed and monumental study of the crime problem in the United States the President's Commission on Law Enforcement and Administration of Justice²³ provided a rather grim picture regarding our handling of the problems of delinquency and crime. In commenting upon the general state of our criminal justice system the Commission set forth a very clear challenge to mental health and other social systems to make their full contribution toward addressing a major societal problem. The Commission remarked:

"In sum, America's system of criminal justice is over-crowded and overworked, undermanned, underfinanced, and very often misunderstood. It needs more information and more knowledge. It needs more technical resources. It needs more coordination among its many parts. It needs more public support. It needs the help of community programs and institutions in dealing with offenders and potential offenders. It needs, above all, the willingness to re-examine old ways of doing things, to reform itself, to experiment, to run risks, to dare. It needs vision."

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Arthur A. Woloshin, M.D.

Jerome Goldberg, LL.B.

Development of Community Mental Health Programs in the Civil Area

The authors review the relationship of law to mental health programs and note that historically society has been concerned with the removal and containment of the psychiatric patient. The courts have not paid much attention to the rights of mental patients. With modern concepts of community treatment, the law must respond to the needs of society and the mentally ill. They conclude that the future will see more cases concerning the mentally ill at the appellate level, an increased adversary nature to mental health hearings and a confrontation between the courts, the legislators and mental health professionals over the public's demands for immediate service for every category.

No other specialty of medicine has as much contact with and regulation by the law as does the field of psychiatry. The origin of this relationship reflects society's concern for its protection from the imputed violence of the mentally ill. Mental health codes in large part reflect society's view of mental illness and provide an orderly process for institutionalization of emotionally ill people. Mental health codes, however,

do not necessarily correctly reflect current medical and psychiatric understanding of emotional illness. It is our hypothesis that community mental health programs, to be effective, will need a realignment of the law and judiciary with the more accurate, dynamic understanding of psychopathology of the mental health professional.

The typical progressive mental health code sets forth a simplified process for admitting individuals voluntarily as well as involuntarily to an institution for care,

Dr. Woloshin, former director of the Northwest Subzone of the Illinois Department of Mental Health, is now in private practice. Requests for reprints may be sent to him at 1866 Sheridan Road, Highland Park, Ill. 60035. Mr. Goldberg is special counsel to the Department of Mental Health in Illinois.

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custody and treatment. Probably the first assumption by a community is the need to remove an emotionally ill individual for the protection of his family and community. The second assumption would be that such removal from the community for psychiatric hospitalization would help the patient receive treatment for his recovery and return to society. Only within the past 100 years have questions arisen concerning provisions for safeguarding the patient's civil rights. More recently, in 1966, the Rouse Case has highlighted the question of adequacy and right to treatment by specifying that the purpose of involuntary hospitalization is treatment, not punishment. The principal issues raised by Rouse are whether a person involuntarily committed to a mental hospital in being acquitted of an offense by reason of insanity, has a right to treatment that is cognizable for habeas corpus, and, if so, how violation of this right may be established. Thus, there has been a gradual albeit slow progression from concern with removal and containment of the psychiatric patient to a more human understanding and treatment of him related to modern day understanding.

Each year approximately 250,000 patients are committed to mental hospitals, most of them involuntarily.¹ An individual in committed status suffers a loss of civil liberties, insofar that in most states he is automatically considered legally incompetent, cannot vote, make a valid contract, marry, divorce, communicate freely with the outside, operate a motor vehicle, etc. For these reasons lawyers as well as psychiatrists have taken an interest in the procedures concerning involuntary commitment. In this instance, however, a common interest does not mean a common viewpoint, for there is a debate between lawyers and doctors as to what should be the method for involuntary commitment and detention.

Medical vs. Legal Points of View

Disagreements between the medical and legal profession in relationship to the civil area can probably best be summarized as follows: The medical profession favors "easy" commitment procedures. The profession believes that the needs of the patient are best met by allowing for rapid placement in the mental hospital without legal qualifications. For example, the doctors believe that: rules of evidence exclude much that is medically relevant; the atmosphere of the courtroom has a punitive aura; the terminology of the law is traumatic to sensitive people; excessive legalism discourages families from seeking early medical care, and so on. The legal profession, on the other hand, favors "strict" commitment. Lawyers believe that the individual's civil liberties are best served if the due process of law is not removed. In the words of one legal authority, "We need the limited requirement of due process. Every man should be entitled to a fair hearing, on notice, should he be threatened with confinement."²

There are many other controversial issues in this debate. Many questions center about (1) the merits of jury decisions, (2) the notification and presence of the patient at his hearing, (3) the patient's right to legal counsel, (4) railroading, (5) the need for a psychiatric "watchdog agency", and even (6) the correct definition of mental illness. One of the areas of debate by the two professions relates to the concern of authority and decision-making. The medical profession believes "provisions should be made for involuntary hospitalization without the necessity of court proceedings."³ They argue that the question of commitment is a medical decision. Either the person is, or is not, mentally ill. If he is mentally ill, he must be admitted or committed and given treat-

ment as rapidly as possible. The problem is simply one of diagnosis and treatment.

Lawyers, on the other hand, argue that the situation is not that simple. They state that the problem is basically a legal one due to the loss of civil liberties which results from commitment. The legal profession appears to view the mental hospital as a "corrective institution" similar to a prison, whose main functions are incarceration, custodial care, and rehabilitation.⁴ The due process of law must be served if anyone is committed to such an institution. Furthermore, Ross states that there are two reasons, besides the obvious loss of civil liberties, why commitment is not a purely medical matter. First, mental illness is not a fact in the same sense as a broken leg: he believes it is a theory used to explain deviant behavior. Second, the psychiatrist is not the person necessarily most qualified to decide on commitment because of the legal problems involved. Ultimate authority in decisions of commitment must reside in the courts.

Historical Perspective

Historically, the legal problems of commitment developed after the establishment of hospitals for detention and care of the mentally ill.

The term "state hospital" has been synonymous with "mental hospital" for more than a century. However, the state hospital as we know it today is a phenomenon of the middle and latter part of the 19th century. It took its form and shape following what is probably the golden era of psychiatry in American history—the period of moral treatment c.a. 1810–1850. What was moral treatment? It was first formulated by the Frenchman Pinel in 1795 into a system "so soundly conceived and dramatically presented that it caught the attention of the

public."⁵ By 1811, T. Romeyn Beck, a New York physician, could write convincingly about moral management of the mentally ill, which, he said, "consists of removing patients from their residence to some proper asylum and for this purpose a calm retreat in the country is desired for it is found that continuance at home aggravates the disease as the improper association of ideas cannot be destroyed."⁶ Central to moral management was "human vigilance", which "had to convince the lunatics that the position of the physician and keeper is absolute." It also depended on "humane attendants who shall act as servants to them (the patients), never threaten but execute, offer no indignities as they have a high sense of honor."⁷ In moral treatment the patient was made comfortable, his interest aroused, his friendship invited and discussion of his troubles encouraged. His time was managed and filled with purposeful activity.

Early psychiatrists used the word "moral" as the equivalent of "emotional" or "psychological". It was also apparent that during this era of the 19th century the society was characterized by small towns, church-oriented, close families, and a relative static technology. Life in the mental hospital or retreats as they were called, then were patterned after life in the community. For example, the superintendent and his family lived with the patients and the patient population was defined as part of the superintendent's extended family.

Towards the middle of the 19th century mass immigration from Europe to America began. The new immigrants who came were from a different culture and spoke a different language. It was easy to see them as a lower species of man. This depreciated view of their fellow man allowed the established Yankees to forsake moral treatment and substitute dehuman-

ization. Dehumanization was manifest by the failure of one group to react to another group as people in assuming that their needs were lower or not as valid as the in-group. For example, keepers of the insane in jails believed that their inmates did not require heat.

The flood of hungry, poverty-stricken immigrants overwhelmed the resources and capacity of the community and doomed the moral treatment movement to failure. The small patient-staff ratio asylum gave way to the over-crowded, distant, state hospitals that offered increasing involvement with procedural problems to the detriment of human needs.*

Community Mental Health—First Stirrings

Like moral reform the community mental health movement received its first encouragement from the professional community. Such innovations as dynamic psychotherapy, chemotherapy and open hospitals were important steps toward community-based services. The psychotropic drugs, which could control some of the psychotic behavior, made the patient more acceptable and less frightening within his family and community. These advances in patient management were followed by enabling legislation in several states which gave support to decentralization of mental health services and to changes in the function of the isolated custodial hospital. Interest in community mental health was supported at the highest level of government by the Report of the Joint Commission on Mental Illness and Health (Action for Mental

Health) in 1961. More than a hundred years after President Franklin Pierce vetoed a mental health land grant proposal, President John F. Kennedy's message on mental illness and mental retardation opened the door for new developments which inevitably led to the federal program for comprehensive community mental health supported by grants for the construction and staffing of mental health centers. These new mental health centers had to provide five elements of service; namely, outpatient, inpatient, partial hospitalization, emergency and consultation-education. In a sense one might say that the mentally ill had finally returned home to their community with governmental sanction. Whether they will stay home is a matter of conjecture.

The concepts of mental illness and treatment of it have changed over the past 150 years. Formerly it was believed that the mentally ill were "crazed", "irresponsible", and "insane", which necessitated their extrusion from the community, long term commitment to an institution, and removal of their civil rights. There are still many people whose first word association with the mention of mental illness is "irresponsibility". The actions which follow this association result in forcing upon the patient the unwelcome experience of being treated as irresponsible. The concept of mental illness which causes such associations is quite at variance with our knowledge of the nature of mental illness, the possibilities for their treatment, and the rights which persons affected by them should possess. Our experiences indicate and we assume that if the community mental health movement performs anywhere close to expectation, the number of committed patients will substantially decrease and in turn, mental health facilities will serve, in the main, patients who come in of their own free will.

* For a further discussion of moral treatment and a comparison with community mental health, the reader is referred to the articles in the historical section of this issue.

Among psychiatrists there does seem to be agreement on one point, namely that treatment of a patient generally yields the best results when it is voluntarily accepted. The question is raised, therefore, will the role of the courts diminish proportionately to the number of involuntarily committed patients? Is there any substantial role for the judiciary at a time when civil rights will no longer be a significant issue? We would like to try to offer some answers as related to our work in this field and limited to a major extent by our powers of predictability.

Public Pressure and the Future

In our opinion the immediate concerns of the public today are demands for services; indignation and concern over lack of facilities and programs for such categories as children and adolescents, alcoholics, drug addicts and geriatric patients; and indignation at what is believed to be a premature or inappropriate discharge. The traditional community mental health facility is financed in whole or in part by public tax funds and will presumably serve in large part voluntary patients. It guards the right to plan and direct its particular programs which will, of necessity, include and exclude certain categories of patients and types of illnesses. It insists for conceptual reasons on serving only certain geographical areas. It plans its program so as to be in a position to control both the type and quantity of persons treated. There may be therapeutic justification for some or all of these policies. When issues are put this way there begins to emerge a series of important and pressing questions. Will the public permit these types of inclusions and exclusions no matter what their apparent justification? Will the geographical allocations be attacked by socially disadvantaged groups on the basis of discrimination or second-class

service? In the absence of any suitable alternative placements, will a community mental health facility be permitted the option of declining a particular category or individual on the basis of lack of funds, lack of staff, lack of program or overcrowding? Will a dissatisfied and demanding public insist, therapeutic and program justifications aside, that all community mental health facilities provide all services for all categories of mental illness without regard to the reasons offered for inability to serve the public?

The luxury of having a community mental health facility decide on the nature and extent of its program, the types and categories and patients it will include or exclude, what neighborhoods it will serve or not serve, will necessarily conflict head-on with the public's demand that all categories of afflicted individuals be treated promptly, humanely and appropriately and, if necessary, with the court's assistance. It is our prediction that the courts will become more active in this area in dealing with the "task of fashioning tolerable accommodations between competing values."⁶

Recent judicial decisions overturning residency requirements for welfare eligibility suggest that the courts, while sympathetic, will not accede to arguments that a judicially mandated policy may bankrupt a governmental body due to lack of funds. In addition, there is reflected in the law as well as state mental health codes the doctrine that most therapeutic decisions must be made utilizing the medical model. In other words, who is allowed to treat whom? For example, admission, treatment and discharge are considered to be the province of the physician or psychiatrist and in the case of mental retardation, the psychologist. On the other hand, as a matter of practice, many of these decisions are being made by a non-medical member of the therapeutic

team, frequently without medical guidance or consultation. The justification offered is that frequently the non-medical member such as a psychiatric social worker is better qualified by education and experience than the possessor of a medical degree who may have no or limited experience in diagnosing and treatment of mental illness. To date, the law has not given recognition to what is the practice, nor does it seem it will do so of its own accord, given the reliance of the public upon the medical model.

Without a program of education and persuasion which will result in a legislative mandate to the courts giving recognition to the non-medical therapeutic individual, it is expected that the community mental health facility will continue to operate illegally and will be subjected to further pressures by members of the public. There will, therefore, be not only the demand for services of every type and quality and category for every disabled individual, but the further demands that treatment be given by a psychiatrist and, even further, a child psychiatrist or one specializing in addiction, alcoholism or other particular illnesses. Depending upon the nature of the presenting disease, the public may not accede to non-medical professional treatment no matter how capable, unless there is judiciary recognized approval of this type of treatment.

The law is derived from the results of human experience. It sets regulations for a somewhat indefinite extension into the future on the basis of what has been learned from the past. It is not immutable and its posture changes with that of society's. What we professionals bring to it in the way of established knowledge, it will heed but is wary of premature acceptance of opinion as contrasted with established knowledge since such acceptance may soon require reversal. It expects to find a considerable measure of agreement among professionals

who presumably speak with the authority of knowledge.

Conclusions

In conclusion, we would like to note a few observations which we think support our hypotheses in seeing a change in judicial functions in the civil area.

1. Until recently there was little or no tradition in either the medical or legal professions of interest in the area of mental health and law. Apparently it is viewed by both professions as a subordinated stepchild to the main tasks of the profession. With the exception of Judge Bazelon's court, relatively little consideration has emerged from appellate courts and particularly the U. S. Supreme Court concerning mental illness. In comparison to other social problems such as civil rights or indigent criminals, there has been a paucity of legal decisions related to the rights of the mentally ill and rights to treatment. It is our feeling that more cases will come to the appellate level concerning the mentally ill.

2. Mental health hearings currently do not have the attributes of an adversary proceeding. Patients tend to be represented by passive public defenders who are not familiar with the legal aspects of the rights of the mentally ill. There tends also to be a lack of organization on the part of the mental health professionals to see that the mentally ill are in fact adequately and properly represented.

3. There is in our opinion a clear warning on the horizon of an impending confrontation between the courts, the legislators, and mental health professionals and the public's demands for immediate service for every category without excuses. This has been precipitated by promises made to the public by all parties involved and a failure by those parties to perform to the

level expected. This confrontation will be exacerbated if nothing is done. How to develop necessary dialogue now between the mental health planners and professionals, the courts, legislators, and the public is a problem to which we will all have to address ourselves. For men of good will, reasonably endowed with intellect, it should present a challenge worthy of acceptance.

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A. Louis McGarry, M.D.

Titicut Follies Revisited—A long range plan for the mentally disordered offender in Massachusetts

While the increased availability of community treatment has been of great help to many of the mentally ill, the mentally ill offender has not been affected. Community facilities, with their open door policies, are hesitant about accepting patients who might be security risks. The author describes a plan for community treatment developed by a governor's advisory committee which would provide for short-term institutional care for such patients. A new facility would be built in Boston that would serve a training function, a halfway function with active treatment and as a treatment resource for parolees, probationers and others of the impulse character disorders. Satellite units would be established in six other regions of the state.

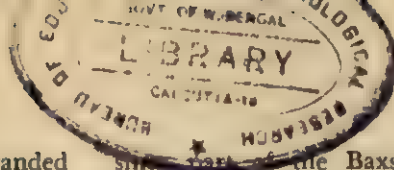
Introduction

There have been steady decreases in the resident patient population in public mental hospitals from 1955 to 1968, during what could be termed the Community Mental Health Era. While increased staff-patient ratios, the widespread use of effective anti-psychotic chemicals and the increased use of general and community hospitals have been important, one strong factor in this decline has been the increasing access of the patient to his community and of his community to the patient.

Dr. McGarry is the Director of Legal Medicine for the Department of Mental Health of the Commonwealth of Massachusetts, 33 Broad St., Boston, Mass. 02109. He is also Assistant Clinical Professor of Psychiatry, Boston University School of Medicine and lecturer on psychiatry at the Laboratory of Community Psychiatry of Harvard Medical School.

However, for one segment of our patient population, the advances of the past dozen years have tended to make a bad situation even worse. I refer to the patient who is regarded as a security risk and an alien in our open door facilities. The administrators of open door hospitals have resisted responsibility for managing the security patient. Their view that the business of security is not the affair of an open door institution and the therapeutic nihilism regarding the offender or potential offender has been raised almost to the level of an article of faith. Security management

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is identified with punishment and branded as anti-therapeutic—perhaps even a crime in itself.

Massachusetts Experience

In my own state of Massachusetts during this era there has been increasing pressure to use the facilities of our maximum security state hospital at Bridgewater, an institution run by the Department of Correction, rather than to use the open hospitals of the Department of Mental Health. Until recently there has been stiffened resistance to the transfer back to or out to institutions of the Department of Mental Health from Bridgewater. The result was that by the early and mid-1960s, Bridgewater was grossly overcrowded. In 1963, there were 759 men hospitalized at an institution with only three physicians caring for them.

Over the last several years, however, important court decisions have had a striking effect in reversing the trend toward greater and greater use of Bridgewater. I refer in particular to the Supreme Court decision *Baxstrom v. Herold*, which has had profound effects both on our Bridgewater institution in Massachusetts and on Dannemora and Matteawan in the state of New York.

The Baxstrom issue turned on a question of due process, specifically that an individual who is to be civilly committed to an institution such as a Bridgewater must have the same safeguards as persons civilly committed to non-security mental hospitals. In the New York case, Baxstrom had been committed without the opportunity for a jury trial.

This decision forced New York and Massachusetts, at least, to provide adequate judicial review of the necessity for commitment in a maximum security institution

since the Baxstrom decision required the specific judicial finding that the individual was so dangerous as to require strict security before he could properly be committed to a maximum security institution on civil grounds. New York interpreted this decision as requiring the mass transfer of some 969 men out of Matteawan and Dannemora and into the institutions of the Department of Mental Hygiene. In a one year follow-up of these 969 men, Hunt and Wiley² reported that only seven had required transfer back to maximum security. It is important to note that most, if not all, of these 969 men had been reviewed for potential transfer to a civil hospital in New York and had been turned down.

In Massachusetts in 1968, 246 men were given similar judicial reviews and only nine were adjudicated as so dangerous as to require Bridgewater. In the year since our transfer of 237 of these men, none have had to be sent back to Bridgewater administratively. Two, having reached the community, committed offenses, or were alleged to have committed offenses, and have been returned under criminal sanctions.

Let us take a look at one segment of the men who had accumulated at Bridgewater and on whom there has been adequate study and follow-up. Late in 1963, the state commissioners of Mental Health and Correction in Massachusetts, aware of the growing problem at Bridgewater and the inadequacy of the staff there for its increasing responsibilities, requested that the Law Medicine Institute of Boston University, which I among others represented, assist Bridgewater. We chose to focus on a population of 219 men who had been indefinitely committed to Bridgewater.

Prior to 1960, only a handful of men committed in this status to Bridgewater had ever been returned to trial, although in the

early years of the 1960s an increasing number were beginning to be returned. We examined 204 of the 219 men hospitalized at Bridgewater as of December 31, 1963, awaiting trial and indefinitely committed. The hospital staff, independently of our efforts, resolved 15 cases before we reached them in our survey. Through the combined efforts of our group and the Bridgewater staff, 79 men of the original 219 were either returned to trial or had their charges dismissed or not prosed. Of these, 42 reached the community. Twenty-six have remained in the community for periods ranging from 18 months to 3 years as of the summer of 1968. Some of these patients were serving time, some have been re-hospitalized elsewhere, and a few have gotten into trouble with the law, 4 out of 42 for alleged felonies. It is worthy of note that 53 men were returned to trial as competent to stand trial. An important point is that of the 53 men returned to stand trial, 35 had been at Bridgewater less than two years. The mean length of hospitalization of the 53 who were able to stand trial was 3.7 years, and this group included three remarkable gentlemen who had been hospitalized 42, 39 and 17 years respectively. The mean length of hospitalization of the 147 who were unable to return to trial was 15 years. The implications are clear. The majority (35 out of 61) who had been hospitalized less than two years were in fact returned for trial. It seems quite obvious that this is a waste of human resources. Many of those 147 men consigned to decades of incarceration and hopelessness could long since have been tried and ultimately reached the community.

It seems clear that the classic mistakes of the pre-community mental health era in American psychiatry are exemplified in this group of men. The labeling, the iso-

lation, both geographic and human, inadequate programs, low professional status of staff, absence of periodical review and custodial care are all here.

Longitudinal Data Relating to the Use of Bridgewater

In order to document the growing use of maximum security during the historical era which we have been examining, I will briefly review in this section of the paper the statistics of hospitalization regarding this segment of alleged offenders, i.e., men accused of crimes and sent by order of the court for pre-trial observation. In 1957 (the statistics for Bridgewater do not go back beyond 1957 with any reliability) 137 men were sent for pre-trial observation to Bridgewater. In the same year, 812 men and women were sent to the institutions of the Department of Mental Health for pre-trial observation. By 1968, the number of persons sent to our institutions of the Department of Mental Health had increased from 812 to 1393, an increase of approximately 65%. Bridgewater, however, had increased from 137 to 395 admissions for pre-trial observations, an increase of over 200%. At the rate of pre-trial admissions to Bridgewater this year (there were 173 between January and May), Bridgewater may well exceed 500 for pre-trial examination.

I do not contend that the resistance to management of security patients is the sole reason for the relatively greater increase in admissions to Bridgewater, but I would contend that it is a major factor. In a retrospective study of 107 persons sent to one of our mental health hospitals in 1960, for example, three escaped during the observational period. Our judges have learned painfully that the state hospitals of the mental health department are reluctant to assume responsibility for security, and little

effort is made in our open door facilities to enforce security.

The More Recent History of Bridgewater

Despite the increasing admissions to Bridgewater quiet headway has been made in reducing the census of that institution by the mid-sixties. Bridgewater began to send men back to trial in increasing numbers who had previously been regarded as incompetent. Persons indefinitely committed awaiting trial in fact diminished in absolute number despite the sharp increases in the number of admissions for observation. Therefore, the census at the Bridgewater State Hospital, which stood at 759 at the end of 1963, stood at 691 at the end of 1965. At about this time, a series of sensational public events forced the community, the legislature and the executive department of government to confront the inadequacies of the Bridgewater program, although improvements, as we have already noted, had begun. Among these events were the celebrated escape of Albert DeSalvo, the self-confessed Boston Strangler, from Bridgewater; the hemorrhagic death of a newly admitted patient to Bridgewater; and, rather late in the series of events, the showing of the controversial film, "Titicut Follies".

Under the pressure of these events, the then Governor of Massachusetts, John Volpe, brought together an advisory committee regarding Bridgewater under the chairmanship of his distinguished Commissioner of Administration and Finance, Anthony DeFalco. This Advisory Committee chose not to limit its study to Bridgewater per se, and appraised the programs for the management of the mentally disordered offender and potential offender throughout the state and devised a long-range plan for Massachusetts in these areas. This author

had the pleasure of drafting the report of the Committee under its direction and the report was presented with its recommendations to the legislature of Massachusetts by the governor on October 13, 1967.

The DeFalco Report

The plan begins with some strengths we have in Massachusetts such as successful programs which have developed over the past fifteen years in the Division of Legal Medicine in the Department of Mental Health. This Division encompasses seventeen psychiatric court clinics located throughout the urban areas of the state. There were, in 1968, 15 full-time psychiatrists and 17 psychiatrists who were half-time or more, working in these court clinics. In addition, there were 14 full-time social workers in the court clinic programs.

In fiscal 1968, 3,800 offenders and their families were seen in evaluation in our court clinic program and approximately 700 were carried in ongoing psychotherapy or casework. In addition to these community programs, the Division of Legal Medicine operates active psychotherapeutic programs within the four major state prisons, and has total clinical responsibility for the Treatment Center for Sexually Dangerous Persons, also located at Bridgewater, with a census of about 150. Last year approximately 1,040 prisoners of our correctional institutions were seen in evaluation, and of these approximately 450 were carried in ongoing group or individual psychotherapy or casework. The responsibilities within these correctional institutions have been borne principally by the social work and psychology disciplines. There were 9 full-time and 6 part-time psychologists and 15 full-time social workers engaged in the in-prison programs.

Within the past year the Department of

Mental Health in Massachusetts has been administratively reorganized and divided into seven regions each with a Director of Legal Medicine second in rank only to the more senior authority of the Regional Administrator himself. These regional directors are primarily administrators with the duty to develop new programs and coordinate existing programs for the public offender.

We already had in Massachusetts a substantial commitment to psychotherapeutic services for the offenders in a most important community agency—the courts. On the other hand, our institutional commitments are to correctional institutions which are geographically isolated and treat incarcerated individuals. We have little in-between beyond aftercare programs (6 social workers and 2 part-time psychiatrists). We do not have institutional programs for offenders close to their communities or available for short-time hospitalization.

We were confronted at the time of writing this report with a set of facts, included among which was that, although Bridgewater had improved some and the census had begun to drop, there were still some 622 men at the institution. We were concerned also on examining the growth of a separate but related institution at Bridgewater, the Treatment Center for Sexually Dangerous Persons, to note that there was a sharp increase in the census at that institution which had risen from 90 on June 30, 1964 to 142 at the time of the writing of the report in 1967. Indefinite commitments had numbered 68 during that period as compared with only 25 discharges.

The unavailability of institutional facilities closer to the community of origin of committed men where varying levels of freedom and controls could be provided, was observed. This forced clinical and judicial authorities to decide for incarceration

at one end of the spectrum of control and almost total freedom at the other, an all or none situation. It was noted that the same all or none situation existed for men in the community, such as parolees, confronted with a return to a correctional institution as the only institutional alternative in handling a loss or regression. This was equally true for probationers, even those who were under court clinic care. Clearly the availability of short-term institutional care for such men close to their community of origin would often provide an alternative to such incarceration.

We therefore completed our report with high hope. At the time, in Massachusetts, there was considerable pressure on the legislature and from the public for new programs to manage what had been exposed as inadequate programs by the sensational events we have referred to. We therefore presented our plan, which became House Bill #5271 of the legislative matters brought before the House of Representatives of the Massachusetts legislature in 1967.

The Plan

In broad outline, we first proposed the establishment of a new facility devoted to legal psychiatry which should be located within the urban boundaries of the City of Boston, where up to two-thirds of our mentally disordered offenders originate. We proposed that this would be an institution with ongoing academic ties and an active program of basic and applied research into the etiology and nosology of criminal behavior. An essential and important feature of this institution would be its training function.

This new institution would provide a halfway function with active treatment for individuals on their way out of the various correctional institutions. Pre-trial examina-

tions of persons accused of major crimes would be a major part of the institution's commitment.

In addition, the institution would provide a treatment resource for parolees, probationers and other of the impulse character disorders in the greater Boston community who could profit from short-term institutionalization with active treatment. The police could utilize the institution as an alternative to criminal prosecution for misdemeanants. Our plan envisioned that this institution would comprise no more than 120 beds and would follow a short-term intensive treatment model with hospitalization lasting no longer than six months. It was planned that as an individual demonstrated an increasing capacity to handle the anxiety and responsibility of community living he would be permitted a gradual return to community responsibility with flexible controls. The standard community mental health features of night hospital, day hospital, work in the community, emergency services, walk-in clinics, and so on, would be provided. The institution, as planned, would be on the grounds of the Boston State Hospital. At the point at which a patient could assume sufficient responsibility and freedom from aggressive behavior he could be integrated into the ongoing programs and life of the hospital community other than the security unit. Inherent in this plan is our acceptance of the necessity for a separate treatment facility for the patient presenting a security risk. Unlike such segregated units in the past, however, which have been characterized by separate but unequal treatment, we would expect to maintain a high staff-patient ratio and excellent care. Should a given patient be unable to profit from and manage his aggressive behavior after a period of intensive treatment, he would be subject to return to the correctional institution from

which he came, depending upon the due process sanctions available to the administrators of the institution.

In the new institution, we would expect to provide an opportunity for sophisticated research and innovative treatment programs. Little has been done, for example, with adult offenders utilizing the principles of learning theory. There are intriguing possibilities of basic research in the impulse disorders. We know little of the endocrinology of the offender. Chromosomal and genetic studies need to be adequately pursued. Drug therapies, specifically designed for the varieties of the offender, are just beginning to have some attention paid to them.

Finally, it was our conviction that the personnel, particularly the nursing and attendant staffing, of such a center would justify provisions for incentive pay because of the specialized training required and the challenge of such an institution, particularly with regard to security.

The place of the Bridgewater State Hospital in the future of Massachusetts was restricted to an institution of some 450 beds. It was seen as the maximum security end of the spectrum of facilities and programs leading toward return to the community. The important provision would be for ease of movement out of Bridgewater toward the community by means of the transitional medium security institutions.

Recent History of Massachusetts Plan for the Mentally Disordered Offender

This brings me to the events of the past 18 months since this plan was presented to the legislature of Massachusetts. At that time we had the enthusiastic support of the executive department of the state government. Governor Volpe and Commissioner DeFalco carried through and requested in the Capital Outlay Budget, the architectural

planning funds for the Center and indeed for four other security units. However, the project did not receive funding in 1968. In addition, much resistance arose against it in the geographic area around the Boston State hospital, and was articulated by the legislative leaders of that part of the city. In our view, this is rather short-sighted on the part of the residents and representatives of the area since security patients do in one way or another arrive at Boston State. Thus, the Center would provide for Boston State security which it does not now have. Nevertheless the resistance is there. We will attempt to deal with this and to quiet the fears of residents on the periphery of Boston State.

In the report of eighteen months ago, we projected that the state hospital at Bridgewater which then had a census of 622 would by the end of 1968 have 400 or fewer in view of the prospective large-scale judicial hearing on the basis of the Baxstrom decision. During the past eighteen months we have successfully reduced the census at Bridgewater far more than our most ambitious expectations. At the present time the census stands at 208 (August 1969). This achievement has been facilitated by a series of factors, perhaps the largest of which is the large-scale judicial review accompanied by the recent willingness of the Department of Mental Health to take in transfer and not to challenge the hospitalization of the great majority of Bridgewater patients reviewed in these hearings.

In addition, over the past eighteen months the Department of Mental Health has accepted 75 to 100 men by administrative transfer. Finally, Bridgewater itself has become much better staffed. At the present time there are eight physicians and approximately thirty nurses and licensed practical nurses at the institution and a half dozen social workers. Fewer of the men sentenced

for pre-trial observation, even though they are being sent in in greater numbers, as we have seen, are being committed. We find ourselves then with 208 men hospitalized at an institution which now in fact has been funded to build an institution of 450 beds. This was not completely unexpected by the planners on the Governor's Advisory Committee.

My proposal at this point would be that the new institution at Bridgewater of 450 beds, which is on the drawing board, would embrace the care and treatment of its current population, and in addition would assume within its walls the specialized care and treatment of persons committed as sexually dangerous persons who are now housed elsewhere in the Bridgewater complex in ancient facilities. Finally, persons who at the present time are committed to the Institute for Defective Delinquents at Bridgewater could also be managed at the state hospital of the new Bridgewater. Thus we would have a new institution with varied clinical statuses but having in common some degree of emotional disorder and the need for strict security. I do not think it inappropriate to note that a factor in the commitment of funds to a new facility at Bridgewater was the economically deprived condition of the southeastern corner of our state and the importance to the economy of the area of the Bridgewater facility.

Summary

At the present time, obtaining architectural funds for the center is the number one priority in the capital outlay request of the Department of Mental Health in Massachusetts for funding this year. However, we have a new governor by virtue of Governor Volpe's having accepted a post in the Cabinet of President Nixon. The same leadership, therefore, which was committed

to the planning of the Governor's Advisory Committee of eighteen months ago no longer exists. In addition, Massachusetts is in a serious financial crisis. Any new expenditures or proposed expenditures are being examined and re-examined for their necessity and validity.

It remains to be seen whether we will be able to carry through the plan. We may find that in the interim we have done too good a job of clearing out Bridgewater. The tragic reality, however, is that without such alternatives it will be extremely difficult to avoid climbing censuses and custodial warehousing phenomena at the several units of Bridgewater in the years to come. I would note that the Treatment Center for Sexually Dangerous Persons is finding it increasingly difficult to successfully transfer, parole or discharge men from that unit,

even when the professionals involved are in favor of such transfer or discharge. I hope we will not be looking forward to a repetition of the tragic events of the last several years in which we have found hundreds of men kept long years beyond what has been demonstrated to have been necessary. We will do our best to be vigilant against the development of such travesties. In any case, I would suggest that the follies which have been exposed in the work of the last five years in Massachusetts are not limited to that part of our country which was once known by its old Indian name "Titicut".

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Arthur Zitrin, M.D.

Morris Herman, M.D.

Yorihiko Kumasaka, M.D.

New York's Mental Hygiene Law —A Preliminary Evaluation

The authors studied the effects of revised New York statutes governing the hospitalization and discharge of the mentally ill on initial hospitalization. Under the new law enacted in 1965, a patient hospitalized on a two-physician certificate is entitled to request a court hearing at any time prior to the end of the 60-day hospitalization period. He may receive assistance from the Mental Health Information Service, a legal service provided by the state. Findings show that there is a trend toward out-of-court resolution in cases where a patient has requested a court hearing. The majority of such cases resulted in discharge by psychiatrists. Before the new law they would have come before the court and been hospitalized. Variations were found in implementation of the law in different parts of the state. The authors also examine the factors affecting the judicial determination.

Since September 1, 1965, an extensively revised New York State statute governing the hospitalization and discharge of the mentally ill has been in effect. The new law includes a number of modifications of procedures for both voluntary and involuntary hospitalization of psychiatric patients. It also established a special service, the Mental Health Information Service (MHIS) in each of the four Judicial Departments

of the State, responsible to the Appellate Division of each Department. The Mental Health Information Service, staffed primarily by lawyers, reviews the status of involuntary patients, informs them of their rights under the law, including the right to be represented by legal counsel and to seek

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The authors are with the Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, N. Y. 10016.

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independent medical opinion, and assembles information for the court whenever a hearing on the involuntary hospitalization of a patient is requested.

The new law has separate provisions for effecting the patient's initial hospitalization and for subsequent extension of hospitalization. An evaluation of the effects of the statutory changes on procedures in New York State must therefore distinguish between the effects on practices at each of these stages. This paper examines those changes which have occurred in the initial hospitalization of the mentally ill in New York since September 1965.

Old and New Procedures

In New York State, as in most other states, admission to state mental hospitals generally occurs directly from the community or after initial admission to a general hospital. Therefore, the general hospital acts as the receiving hospital in the initial hospitalization of the psychiatric patient. The new law made no essential change in the admission of patients to the psychiatric units of general hospitals. Section 78 of the 1965 Mental Hygiene Law authorizes the admission and confinement of such patients for up to 30 days in a designated general hospital for observation and treatment. If a patient requests discharge, the hospital has ten days within which to make a disposition. A patient admitted on this basis to a general hospital, if not discharged, may be retained there or transferred to a state hospital either on a voluntary basis or involuntarily, that is, on a two-physician certificate.

A patient hospitalized on a two-physician certificate may be detained for up to 60 days. The patient is entitled to request a court hearing at any time prior to the expiration of this 60-day period. The new law makes it mandatory for the hospital to give

notice to the patient, and to as many as three other persons whom the patient may designate, and to the MHIS, of the intention to retain the patient on a two-physician certificate or of the decision to send him to a state hospital on such a certificate. The notice contains information about the patient's rights and about the availability of the Mental Health Information Service. As the system now operates, the hospital provides the MHIS with a copy of the two-physician certificate. When a court hearing is scheduled at the request of either the patient or of someone else on his behalf, an MHIS officer gathers information for presentation to the court, relying partly on the hospital record and partly on data obtained through his own inquiry. If the court determines that the patient requires further hospitalization, it signs an order authorizing the retention of the patient for an additional period not to exceed six months. For

One of the findings of the Committee was that judges outside New York City rarely heard patients prior to their being sent to state hospitals by court certification. In one up-state county no judicial hearings had been held for such patients during the 10 years preceding the study.

the patient who has not exercised his right to a hearing during the initial 60-day period a judicial order for further hospitalization is mandatory unless the patient agrees to remain on a voluntary basis. Under the new law a second judicial authorization, after the six month hospitalization, is for a one year period and all subsequent judicial retention orders are for periods of two years. Before each renewal of the court authorization for retention the patient is

again entitled to a court hearing and to assistance from the MHIS.

Prior to the 1965 revision, the law provided for certification by court order after notice to the patient and his relatives of the recommendation for hospitalization by two physicians and of his right for a hearing. However, the old law also provided that notice to the patient should be dispensed with if the two examining physicians stated in writing that such notice

... judicial procedures under the old law were mere sham. In most jurisdictions hearings were rarely held and in many cases even those were regarded as inadequate to protect the patient.

would be detrimental to the patient.¹ The initial judicial certification was for 60 days, both for patients who had a hearing and for those who did not request one. The state hospital director filed a certificate at the county clerk's office attesting the patient's need for further care. Judicial review of such extension was not required. At any time the hospital director had the right to terminate the status of certification by discharging the patient or by placing him on convalescent care status (conditional discharge). In the latter case, final certification was still in force and the patient could be returned to the hospital when re-institutionalization was medically indicated. Under the new law, a hospital director can still place a patient on convalescent care status, but only for the remaining period of his court-authorized hospitalization.

The revised law incorporated a number of findings and recommendations of a Special Committee of the New York Bar Association which, from 1960 to 1962, studied the operation of the Mental Hy-

giene Statute.² One of the findings of the Committee was that judges outside New York City rarely heard patients prior to their being sent to state hospitals by court certification. In one upstate county no judicial hearings had been held for such patients during the 10 years preceding the study.² Although hearings were much more common in New York City, the value of many was questioned by the Committee. For example, at Kings County Hospital, the practice was for judges to see every patient for whom state hospitalization had been recommended, including those who had not requested a hearing. As a result, about 70% of 4,000 patients civilly committed from Kings County Hospital in New York City were seen by the judges before certification. The remaining 30% were reported to the court to be too physically ill or too disturbed to make an appearance in the court. This meant that a judge saw as many as 80 or 100 patients in a single morning. At Bellevue Hospital, on the other hand, the practice was for judges to hear only those patients who requested a court hearing, and they were thus able to spend more time on each case than at Kings County. In 1960, about 11% of 4,700 civil patients certified at Bellevue appeared in hearings before the judge. These patients were rarely represented by counsel. Those who were, were usually patients who retained private lawyers, although occasionally Legal Aid counsel was provided at the request of the patient or the court. The Special Committee of the Bar Association, reporting on these practices, stated, "If we face the facts, the conclusion is inescapable that initial admission under Section 74 (admission on court certification) fails in most of these areas to live up to its pretension of being a judicial admission and has become in substance although not in form a medical admission."²

The Role of the MHIS

The state-wide MHIS is authorized to employ a total of 11 persons in supervisory positions and 43 staff persons.³ Since the New York judiciary is administratively divided into four Judicial Departments, the MHIS also operates in four units, one under each Department. The MHIS staff in the First and Second Judicial Departments, which cover New York City and the surrounding areas, are mostly lawyers, while social workers and former probation officers comprise the bulk of the staff in the Third and Fourth Departments serving upstate New York.

Each MHIS unit maintains a different approach to arranging for objecting patients' representation at a hearing by legal counsel. The staff lawyers of the MHIS unit in the First Department act as counsel for the patient in court if the patient has no lawyer of his own. In contrast, staff lawyers of the MHIS unit in the Second Department conceive their role as one of liaison between the judge and the patient, and arrange for a lawyer from a bar association to represent the patient. MHIS staff officers are stationed in key hospitals (for example, seven to eight lawyers at Bellevue Hospital in Manhattan), and are periodically assigned to the smaller hospitals. They routinely exchange information and opinion on patients, especially those scheduled for a court hearing, with the medical staff. Major receiving hospitals also maintain a courtroom within the hospital where regular Supreme Court justices, sitting on a rotating basis, preside at hearings held once a week.

After familiarizing himself with the case through a written report from MHIS and the medical certificate, the judge often questions the witnesses himself. The testifying psychiatrist, MHIS lawyer, and the patient

are almost always present, and frequently also the relatives and friends of the patient and privately retained lawyers. The proceedings may be brief or lengthy, formal or informal, depending on the nature of the case and the extent of the disagreement between involved parties. A case is not necessarily resolved by one hearing, in terms of release or hospitalization, but may be adjourned to another court day. Some cases are settled out of court before the hearing begins or after adjournment. In these cases either the patient withdraws his objection and agrees to hospitalization or he is discharged by the psychiatrist. Discharge may be to the patient's own custody, or to the custody of a relative or friend, who may promise the hospital or the court to arrange psychiatric treatment in the community for the patient. Should the court wish, it may request the participation of an outside psychiatrist to evaluate the case at the state's expense.

Changes in Rates of Court-Authorized Hospitalization Under the New Law

Under the revised law, there has been dramatic reduction of court-authorized hospitalization in New York State hospitals (Table 1). In fact, the 331 court-authorized admissions in 1967 represent a negligible fraction of the total 41,000 admissions, especially as compared with figures from previous years. However, a meaningful interpretation of this reduction requires knowledge of the details of past and present procedures.

Under the present law, judicial review of initial hospitalization on a two-physician certificate is limited to patients who request it, and these reviews are aided by the Mental Health Information Service in the ways described. Therefore, the figures of

court-authorized admissions under the old procedures are not comparable to the total number of court certifications under the revised law, because they include not only

TABLE 1

*Admissions by Legal Status to New York Civil State Hospitals From 1960 to 1967
(Fiscal year ending March 31)*

Year	Legal Status			Total
	Court-authorized	Voluntary	Other*	
	N	N	N	N
1960	14,480	5,651	6,381	26,512
1961	14,137	6,591	6,307	27,035
1962	12,835	7,064	7,786	27,685
1963	13,107	9,327	8,250	30,684
1964	12,025	9,455	11,538	33,018
1965	11,565	9,545	14,144	35,254
1966	5,200**	11,521***	19,618	36,432
1967	331	14,614	26,032****	40,977

* Including Code of Criminal Procedure.

** The revised Mental Hygiene Law took effect on September 1st, 1965. The number of court-authorized hospitalizations under the old law (until August 31st, 1965) was 4992. Under the new law (from Sept. 1, 1965 until March 31, 1966) the number was 208.

*** 3964 under the old law and 7557 under the new law.

**** Including 17,717 patients on a two-physician certificate.

Source: Statistical Service, Department of Mental Hygiene, Albany, N. Y.

those admissions following hearings (such as those formerly held at Bellevue) but also those without a hearing.

State-wide information pertaining to the number of Bellevue or Kings County type of hearing under the old procedures is not available. However, when the geographical distribution of court-authorized admissions in 1967 is examined (Table 2), we note that 99% of court-authorized admissions were confined to New York City and the sur-

rounding areas, while the 12 upstate hospitals received only one percent of these admissions (three cases in all). If we assume, as seems probable, that there has been no significant increase in the number of court hearings in upstate New York since

TABLE 2

*Court-authorized Admissions and Two-physician Admissions to Individual Civil State Hospitals of New York State in 1967
(Fiscal year ending March 31, 1967)*

State Hospital	Court-authorized Admissions*	Two-Physician Admissions
<i>New York City Area</i>	N	N
Bronx	5	997
Brooklyn	21	1,175
Creedmoor	8	2,784
Manhattan	49	990
Psychiatric Institute	0	11
Rockland	69	1,292
Central Islip	87	1,824
Pilgrim	61	2,484
Kings Park	28	1,523
Sub-total		328
The rest of 12 hospitals upstate		3
Total		331
		Sub-total 13,020
		4,697
		17,717

Source: Statistical Service, Department of Mental Hygiene, State of New York, Albany, N. Y.

* Section 72 only.

1967, then it is clear that the court authorization for almost all of the 328 cases in Table 2 would have been issued at one of the courtrooms in four municipal hospitals in New York City.

Table 3 shows the outcome of requests for a court hearing during the year 1967 at the four municipal hospitals, namely Bellevue (Manhattan), Jacobi (Bronx), Kings County (Brooklyn) and Elmhurst (Queens).¹

TABLE 3

*Distribution of Outcomes of Requests for Court Hearings Under
the Revised Mental Hygiene Law in Four Municipal
Hospitals in 1967 **

Outcome	First Judicial Department				Second Judicial Department			
	Bellevue Hospital		Jacobi Hospital		Kings County Hospital		Elmhurst Hospital	
	N	%	N	%	N	%	N	%
Request withdrawn	125	23.7	41	34.5	13	8.4	3	23.1
Discharged by psychiatrists	158	29.9	68	57.1	25	16.2	3	23.1
Hospitalized by court order	221	41.9	9	7.6	83	53.9	5	38.5
Discharged by court order	24	4.5	1	0.8	33	21.4	2	15.4
Total	528	100.0	119	100.0	154	99.9	13	100.1
Transfers on a two-physician certificate	2851		1610		2995@		2629	

* Pertaining to the initial admissions under Section 72.

‡ Excluding applications from prison wards of Bellevue, Kings County and Elmhurst Hospitals.

@ Including 385 patients who were transferred on a two-physician certificate directly from mental hygiene clinics.

Source: Records compiled by the Mental Health Information Services of the First and Second Judicial Departments excluding the Bellevue Hospital. For Bellevue, the records compiled by the Certification Office of the hospital are used.

The first two hospitals are in the First Judicial Department while the last two hospitals are in the Second Department. The ratio of patients hospitalized on court authorization to patients sent on a two-physician certificate from each municipal hospital varies markedly, from 1:13 (Bellevue) to 1:36 (Kings County), 1:179 (Jacobi) and 1:526 (Elmhurst). Statewide, the ratio was 1:53.

Out-of-Court Settlement

The figures in the columns "Request withdrawn" and "Discharged by psychiatrists" (Table 3) indicate the number of cases which were not judicially determined,

these cases having been resolved out of court. Thus, 53.6% of a total of 528 cases in which requests for hearings were made at Bellevue in 1967 were settled out of court. At Jacobi, the proportion reached as high as 91.6 per cent. At Bellevue Hospital, this high rate of out-of-court settlements in 1967 represents an increase over 1966. While the total of 531 hearing requests in 1966 is nearly the same as the 528 of 1967, 44.8 per cent were settled out of court in 1966.

As already noted, hearings at Bellevue were, and still are, limited to those patients who request judicial review. The same practice was followed at Jacobi. While the total number of requests for a hearing during the old law period is not known, we

have the records of judicial determinations made at Bellevue and at Jacobi from 1964 to 1967 (Table 4). The reduction of total judicial determinations in 1966, after the enactment of the revised law, is marked at both hospitals.

It is clear that there is a trend under the new law for out-of-court resolution of differences of opinion about psychiatric hospitalization, in cases where a patient has requested a court hearing. Under the old law a much larger percentage of such hearing requests would have been settled in the courtroom. For example, in 1964 exactly 300 more cases were resolved by the judges

TABLE 4

Distribution of Judicial Determinations Following a Court Hearing Pertaining to the Initial Hospitalization at the Bellevue and Jacobi Hospitals From 1964 to 1967[†]
(in number)

from January 1st, to December 31st.

	<i>Bellevue Hospital</i>		<i>Jacobi Hospital</i>	
	Judicial Determination			
Year	Hospital- ized	Released	Hospital- ized	Released
	N	N	N	N
1964	538	56	159	0
1965*	591	52	166	2
1966	257	37	14	0
1967	221	24	9	1

[†] Excluding applications from prison ward of the Bellevue Hospital.

* On September 1st, 1965, the revised Mental Hygiene Law took effect.

Source: Certification Offices of the Bellevue and Jacobi Hospitals.

† The statistics of the municipal hospital cover the one year period January-December 1967, whereas the statistics of the state hospital cover the period April, 1966-March, 1967. Therefore, the patients in the column "Hospitalized by court order" are not necessarily the same patients as appear in Tables 1 and 2.

at Bellevue than in 1966, and the overwhelming majority of them were hospitalized by court order. In contrast, the large majority of cases settled out of court in 1966 and 1967 were discharged by psychiatrists. It seems likely, then, that many of those patients who were discharged by psychiatrists following their requests for a court hearing under the new law, would under the old law have come before the court and subsequently been hospitalized.

Discharge rates of two groups

Discharge of the patient following his request for a hearing could be by the psychiatrist, in the pre-hearing period, or during an adjournment, or by the judge after the hearing is held. The overall discharge rate (by both psychiatrist and judge) among the hearing request group was 34.5% at Bellevue in 1967. The patients in the hearing request group come from those who were admitted to Bellevue and for whom further hospitalization in a mental institution was recommended by two psychiatrists. At Bellevue, two-physician certificates were made out for 4,310 patients during 1967. Four hundred forty-five of these patients were eventually discharged directly from Bellevue. As noted in Table 3, 528 patients requested a court hearing in that year and 182 were discharged (34.5% discharge rate). In other words, 263 patients for whom a two-physician certificate was originally recommended were discharged from among those patients who did not request a hearing, the latter group totalling

...in 1967 ... 99% of court-authorized admissions were confined to New York City and the surrounding areas, while the 12 upstate hospitals received only one percent of these admissions.

3,782. The discharge rate from the non-request group is therefore 6.8%. In 1966, this rate was 6.9% as against 33.5% of the hearing request group in that year. Thus for both groups of patients, figures have remained constant during 1966 and 1967.

Although we do not have data on discharge rates for patients who requested a hearing and for those who did not, under the old law, it is our impression that there was a higher rate in the group that asked to appear in court. However we do not believe that the differences were as great as those seen in 1966 and 1967 and we regard these recent changes as direct consequences of the new law.

Discussion

The revision of the New York State Mental Hygiene Law came at a time of increasing nationwide concern about civil rights and individual liberties, particularly of the indigent and disadvantaged in our society. In the field of criminal justice this concern was reflected in the landmark decisions of the U.S. Supreme Court in the cases of *Gideon*, *Escobedo* and *Miranda*. In the political sphere, it was manifested in the voting rights legislation of the past decade and in the Supreme Court one man-one vote decision. The movement toward providing equal educational opportunities for all and the recent federal legislation in the health and welfare fields are other signs of the concern with the rights and needs of all citizens.

The findings of the Special Committee indicated that the judicial procedures under the old law were mere sham. In most jurisdictions hearings were rarely held and in many cases even those were regarded as inadequate to protect the patient. The judges, for the most part, rubber-stamped the psychiatrists' recommendations. The Committee, therefore, recommended that

the initial hospitalization of psychiatric patients be a medical determination, but that there be adequate safeguards for the protection of the civil rights of the patient immediately after his admission.

The new law has been regarded as a possible model by other states for similar revisions of their own statutes governing the care of the mentally ill. For this reason a good deal of interest has focused on how the New York law has worked since its implementation in September 1965.

The study fell naturally into two divisions. The first relates to how the various statutory provisions and administrative regulations are being implemented in various parts of the state, and what effects they have had on the hospitalization of psychiatric patients. The other aspect is concerned with the factors that affect the decision-making processes, particularly the judicial determination, but including the recommendations of the psychiatrist and the other professional persons who may be involved in planning for the disposition of the patients. Some conclusions, as well as many issues for further inquiry, have emerged from the data we have collected so far.

The fact that in 1967 only 331 of a total of 40,977 state hospital admissions were on court order is a dramatic change from the old law figures. Closer investigation will be required to determine, however, whether this number is an accurate sample of all the patients who were entitled to be informed of their rights under the law. Our preliminary findings suggest that many patients may not be receiving the information that the law says should be given them, and that their requests for hearings may sometimes not be honored. It is certainly clear that practices vary in different parts of the state, reflecting differences in attitude of psychiatrists, judges, and members of the MHIS. Differences in practices were

common under the old law as well, as the Special Committee's study pointed out, and it is interesting to note that traditional sectional attitudes seem to have been changed little by the new legislation. The differences between the kinds and numbers of hospitals to be found in rural communities and urban centers, and the differences in availability of psychiatrists, the ease and convenience with which hearings can be held, etc., are probably all factors that account for the variation in practices in different parts of the state. A more detailed study is now in progress to delineate these factors and to determine whether the original aim of the new law, to increase legal protection for the patient, has, in fact, been substantially realized.

Some changes, as a result of the new law, are clearly evident in New York City. At Jacobi Hospital, more than half the patients for whom state hospitalization on a two-physician certificate was recommended in 1967, and who requested a court hearing, were eventually discharged by the psychiatrist. At Bellevue the percentage of such discharges is increasing and reached 35.5% in 1968. There is clearly a trend toward out-of-court resolution of patient dispositions. In hospitals in the First and Second Departments all patients requesting a court hearing receive counsel or assistance from lawyers of the MHIS. It is likely that this is an important contributing factor to the high rate of discharge of these patients. Similar observations have been reported from Ohio.⁴ What is not clear, however, are the mechanisms at play in the complex interactions of the psychiatrist, lawyer and judge. To what extent is the final decision the outcome of a cooperative and mutually respectful effort by law and psychiatry, in

which, despite differences in orientation, these two professions are able to work in harmonious tandem for the good of the patient? To what degree are determinations made as a consequence of a desire to avoid confrontations, and a reluctance of doctors to appear in a court. What part is played by those who regard the return of the patient to the community as the most desirable disposition regardless of other considerations. What are the differences, clinical and demographic, among patients for whom continued hospitalization is initially recommended which may determine whether they will ask for a court hearing, and which also contribute to variations in final disposition? What will follow-ups of these patients after discharge disclose about the correctness of the disposition?

These problems, and others, contribute to the complexity of the issues of involuntary psychiatric hospitalization. The study now in progress at Bellevue Hospital and the New York University Medical Center will, we hope, contribute to our understanding of these questions so that we can continue to improve our care of the mentally ill without abridgment of their legal rights.

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Henry Weihofen, Ph.B., J.D., J.S.D.

Gene L. Usdin, M.D.

Who Is Competent to Make a Will?

Although the courts are agreed on the legal test of mental competency to make a will, the broad wording is not always easy to apply to concrete cases, and so results are not always easily predictable. Courts have given varying weight to such factors as eccentricities, old age, physical disabilities and peculiar religious beliefs. The "shading" or varying degrees of competency add to the complexity of the problem. It is therefore the part of wisdom, if there is any likelihood of a will's being contested, to make sure that the testator is mentally competent and that there will be evidence, as in the form of a psychiatric report, to prove such competence.

Pa, aged 80, who has been getting more cantankerous with advancing age, announces after one of many quarrels with his daughter Ida that he is going to cut Ida out of his will, and leave his money to his nephew Felix. For the past 19 years Pa has made his home with Ida, who has been a good and loving daughter. But with the years Pa has found more and more to complain about—that Ida doesn't take him

along when she goes out, that she doesn't want him around and is only after his money, and even that Ida is trying to poison him. On the other hand, he now finds his nephew Felix to be a charming fellow; his joshing and kidding when he happens to drop by cheers Pa up a lot.

This sort of thing happens all too often. As people grow old, they may become quarrelsome and suspicious, and turn against the very person, like Ida, who is giving them the most love and care. Pa took out his resentments on Ida because she was there. Whatever Ida did, no matter how considerate and right, he saw as inconsiderate and selfish, or as a cover up for evil designs.

Does the law allow Pa to cut off Ida, a loving and deserving relative? One possible

Professor Weihofen teaches law at the University of New Mexico and is Legal Services Coordinator of the Bernalillo County Mental Health-Mental Retardation Center, 2600 Marble Ave., N.E., Albuquerque, N.M. 87106.

Dr. Usdin is Director of Psychiatric Services, Touro Infirmary, 1400 Foucher St., New Orleans, La. 70115 and associate professor of clinical psychiatry at the Louisiana State University School of Medicine in New Orleans.

ground for voiding a will is mental incompetency. It may be contended that Pa lost the capacity to make a rational disposition of his property by will. It may also be contended that Pa had promised to leave his property to Ida perhaps by way of payment for Ida's caring for him during his lifetime, but it is difficult to prove such an agreement, especially when the involved parties are relatives, unless it has been put down in writing.

Legal Requirements

The law on testamentary capacity can be stated in a sentence—A person is mentally competent to make a will if he has: 1. an understanding of the nature of the transaction; 2. a general comprehension of the nature and extent of his estate; and 3. a recollection of the natural objects of his bounty. These three requisites may be defined as follows:

1. Understanding the nature of the act means that the person must know that it is his will that he is signing. If it can be shown that the testator was confused and talking incoherently at the time, or was unable to talk at all, that he didn't seem to recognize the people who were present, that his hand had to be guided in signing, and that he died soon afterward, a psychiatrist or other expert would be likely to conclude that he didn't know he was executing a will.

2. Comprehension of the nature and extent of his property calls for a reasonably correct knowledge of what he owns. If he undertakes to bequeath \$50,000 to his sister Kate and the remainder to his wife, when his entire estate is not and never has been worth that much, a court or jury might later conclude that because of psychotic delusions of grandeur or other mental impairment he did not know the extent of his holdings. If he devises to his son the old

family homestead, which in fact he had sold ten years before, we might also conclude that senility had so far impaired his memory that he didn't know the nature and extent of his property. This requisite is especially important to evaluate when the testator, after making specific bequests, leaves the remainder of the estate to a wife or other close relative, presumably with the intention that such remainder should constitute the bulk of the estate.

3. Knowledge of the "natural objects of his bounty" means that he knows who his living relations are and what their legal or moral claims on him may be. If he insists that his children are all dead, or that the daughter who has been caring for him is not his daughter but an imposter, he is probably incompetent under this criterion. This is the main reason why some wills are drawn leaving \$1.00 to a relative or close friend. It shows that the testator was aware of that person.

These legal requirements are not very stringent, and they are not intended to be. Average intelligence is not required; someone with the intelligence of a moron may be capable of making a valid will. Even a person suffering from a recognized form of mental disorder is not necessarily incompetent. Unless he is so mentally disordered or deficient as to come within the tests set out above, the law does not consider it proper to deprive a person of his right to dispose of his property as he wishes. Wills are therefore difficult to overturn.

The fact that the testator was a patient in a mental hospital at the time he signed the will does not necessarily mean that he was incompetent. That he needed hospital care and treatment does not necessarily mean that he could not understand what he was doing. Of course, that a person was suffering from a recognized form of mental illness, or that he was in a hospital for such

illness, is evidence that weighs on the question of his competency, but it is not conclusive. Indeed, even when a statute or hospital regulation requires a hospitalized patient to get a court order to be allowed to make a will (as in the District of Columbia for retarded patients and in New York for those committed as mentally ill), failure to get such a court order does not void an otherwise valid will.

Moreover, even an adjudication that a person is incompetent and appointment of a guardian for him does not conclusively establish incompetency to make a will. Here too, of course, the fact that the testator was under guardianship at the time he made the will is relevant and admissible in evidence, and in most states this fact has been said to raise a rebuttable presumption of incapacity.

The psychiatrist making the examination should understand what the legal criterion of competency is. It is not enough that the psychiatrist determine whether the person is mentally ill or not, and if so, what diagnostic label to put on the condition. He should focus his questioning of the person on his thinking processes relevant to the criteria for making a valid will.

Adjudication of incompetency shortly after executing the will is admissible as evidence, but the weight given to it depends on the length of time intervening and the type and seriousness of the mental condition proved. One California case held that an incompetency adjudication one month after signing the will does not establish

testamentary incapacity, but does constitute substantial evidence of such incapacity, especially when there was no material change in mental condition in the interim. In a New Mexico case, evidence that a petition for a declaration of incompetency and the appointment of a guardian was filed on the very day that the decedent executed the will, and was granted a week later, was not held conclusive; the court found that the decedent had sufficient capacity.² Suicide, although it may be relevant to the question, does not of itself justify a conclusion of mental incompetency.

Psychiatric Examination

When there is reason to think that a will may be contested—as when the testator is elderly, forgetful or eccentric, and especially when he disposes of his property in a way that will disappoint relatives who were expecting to inherit—it is prudent for the testator to have himself examined by a psychiatrist, or for his lawyer or relatives to persuade him to have such an examination. The testator may resent the suggestion that he submit to such an examination, but if he is told that it may prevent a lawsuit, he is likely to cooperate. The examination should be made at the time the will is drawn, preferably on the same day, and a copy of the psychiatric report should be attached to the will. The psychiatrist might actually be present at the time the will is signed although it then might be argued that those supporting the will were concerned about the testator's mental competency.

The psychiatrist making the examination should understand what the legal criterion of competency is. It is not enough that the psychiatrist determine whether the person is mentally ill or not, and if so, what diagnostic label to put on the condition. He

should focus his questioning of the person on his thinking processes relevant to the criteria for making a valid will. He should, for example, check whether the person is able to name the members of his family and their relationship to him, and talk to him about each of these relatives to see if talking about them produces any undue emotional reaction. Further, he should ask the testator the value of all capital assets he possesses; he should check this information through a reliable source.

The issue of undue influence is raised along with that of mental incompetency in many cases, and the two are often closely interwoven at the trial. In nearly all states, undue influence is a basis for invalidating a will when the will was induced by a domineering relative or friend who used deception, threats or insidious suggestion to take advantage of a person, who, even though not mentally incompetent, was sufficiently weak willed to yield to such coercion. Many old persons, especially if they have always been rather dependent by nature, become childishly dependent as they grow senile, and fall easy prey to flattery and suggestion. Others may give in because they are ill, weak and lonely, and no longer have the physical and emotional stamina to cope with importuning relatives. One sort of case happening all too frequently is that of the elderly patient who leaves a substantial part of his estate to a nursing companion or attendant who may have seemingly been very devoted during the final years of the patient's life, especially about the time the will was drawn. Many will contests have arisen out of such circumstances.

The psychiatric examination should therefore address itself also to the possibility of undue influence. If the examination is made partly in the presence of others and partly alone with the testator, the psychiatrist should be able to observe mood reac-

tions, fears and suggestibility. Such observations and conclusions drawn therefrom should be included in the report.

Having a psychiatric examination is more important in will cases than in others, because if there is going to be a contest over the will, by the time the will is offered for probate the testator is no longer available for examination.

To avoid any later objection that the report or the doctor's testimony is inadmissible in evidence because it was a privileged communication between doctor and patient, it is well to have the testator file with the report his written permission for the examining psychiatrist to inform the court of his findings and conclusions.

The mental illnesses most often involved in will contests are the diseases of old age. And as science increasingly is able to prolong life, these are likely to grow more common. The aging process inevitably takes its toll in mental as well as physical ability. But there is a difference between normal aging and senile psychosis. "Most physicians appreciate that senility is not a chronological fact. It varies with the individual's physiological status, with the personality, with environmental factors, and with superimposed emotional illness."³ People have reached the age of 90 or even 100 without showing marked mental deterioration. Wills made by persons more than 90 or even 100 years old have been upheld by the courts.⁴

But some persons do develop one or another form of senile psychosis, either senile brain disease (also called dementia) or cerebral arteriosclerosis. In both there is impairment of orientation, memory (especially for recent events), judgment, and the higher intellectual functions. The impairment may be so serious that the person falls below the legal test of competence, as where he is disoriented as to time, place and person, forgetful of his own name or address

and the names of his children. Such marked memory loss cannot be considered part of the normal aging process. It may be caused by the chronic brain deterioration of senile dementia or by the shortage of oxygen reaching the brain because of arteriosclerosis, or by acute infection or poisoning or metabolic disturbance because of malnutrition or disease.

Emotions may also contribute. Suspiciousness and resentment may have their roots in the aging person's feelings of loneliness, insecurity and fear. As he feels himself deteriorating physically, socially and financially, he may refuse to face the fact that this is a more or less normal effect of old age and may try instead to put the blame on the younger people around him—as Pa did.

Some forms of mental illness, such as paranoia, are characterized by delusions. If the testator's normal feelings and affections were irrationally displaced by insane suspicion or aversion which led him to dispose of his property in a way differing from the way he presumably would have provided had he been sane, his will should not stand. But the mere fact that he held beliefs that other people might regard as groundless does not mean that these were the products of an insane delusion, nor does the fact that he makes an unfair or peculiar disposition of his property mean that he is mentally incompetent. That a man's suspicions about certain relatives were wrong does not mean that they were the product of a delusion. A person is not required to be fair or just or reasonable in disposing of his property. If he was not suffering from mental illness such as to negate competency, and was not the victim of undue influence or fraud, the law will give effect to his will, even though its provisions are unreasonable and unjust. But juries, and perhaps also judges, have a tendency to be less protective

about a will that seems to them to be unfair to wives or children. The courts therefore try to distinguish, for example, between belief that one's wife is unfaithful based on circumstantial evidence, and a belief based on psychotic delusion. The distinction is not always easy. In a New York case,⁵ the testator had cut off his wife of 40 years with little more than the minimum the law required, because he believed she was unfaithful to him. He first began to express this belief after a series of surgical operations, when he was about 70. He seemed otherwise normal, but this suspicion became an obsession. A year before his death, he went to Europe without telling his wife, and while there he consulted a doctor. He said he was "sick in the head". When he returned he made the will in question. He never again rejoined his wife in their home.

A belief in spiritualism will not of itself invalidate a will; old people may find solace in talking with a spouse or friend long dead. To affect the will, it must be shown that the terms of the will were dictated by the supposed spirits, and not by the testator's own judgment.

To offset this evidence, proponents of the will undertook to show that he had reasonable grounds for his belief. The man he suspected, an old friend, had sent a printed anniversary greeting card; it was addressed to the wife alone, was not received on the anniversary date, and its message was sweetly sentimental. This the decedent took to confirm his suspicion. He found further support in the fact that whenever the tele-

phone rang his wife answered it. Also, one day when he was leaving the house, his wife asked him when she might expect him home. This aroused his suspicion; he secreted himself in a nearby park and saw the suspect enter his home. When he charged his wife with this, she allegedly asked him for a divorce. The wife flatly denied this story. There was also evidence that he had given his attorney other reasons for disposing of his property as he had: his wife's independent fortune and the financial need of his residual legatees.

The jury found that the testator was not of sound mind and memory at the time he executed the will. The Appellate Division reversed, finding that there were sound reasons for his disposition. This decision was in turn reversed by the New York Court of Appeals, which found that a preponderance of the evidence established that the belief of infidelity was an obsession with the testator and so raised a question whether this obsession affected the will.

A delusion may affect testamentary capacity when it: 1. goes to the instrument, as where the testator believes he is being forced to sign it; or 2. goes to the property to be disposed of as where he is deluded as to how rich or how poor he is; or 3. concerns his relatives or others having claims on him, as where he has paranoid delusions that some of them are trying to poison him; or 4. concerns the disposition, as where he leaves his property for a peculiar purpose or makes a bizarre choice of beneficiary. Sometimes the delusion is a combination of two or more of these types.

Delusions of having received divine or supernatural directions for disposing of one's property are not uncommon. Wills disinheriting close relatives in favor of a church or religious order have been set aside when the disposition was dictated by spirit voices or visions. But courts are reluc-

tant to reject as delusions any particular forms of religious belief, even those that seem bizarre. A belief in spiritualism will not of itself invalidate a will; old people may find solace in talking with a spouse or friend long dead. To affect the will, it must be shown that the terms of the will were dictated by the supposed spirits, and not by the testator's own judgment.

Delusions of grandeur or of poverty may also invalidate a will if they affect ability to appreciate the nature and extent of the property. Delusions of marital infidelity are pathetically frequent in certain mental illnesses, especially the involuntional psychoses and senile psychosis. An innocent (and perhaps old and feeble) spouse may be fancied guilty of the most flagrant misconduct. Delusions of persecution are frequent in senile psychosis, and in a major type of schizophrenia. Such delusions may generate strong hatred, often against some member of the family.

A delusional state is typically not static; it may fluctuate materially. A patient who at one time tells of a gigantic and ramified plot against his life may at another time talk about how people in general are after him, and at still another time merely express the feeling that people are untrustworthy. The law recognizes the possibility that a person suffering from a mental illness serious enough to render him incompetent may have intervals during which his mental capacity is significantly higher than at other times. During such a "lucid interval", he may be competent to execute a will or perhaps to perform other legal acts. This is more likely to happen in certain types of illness, such as cerebral arteriosclerosis, for example, than in others, such as senile dementia.⁸

A psychiatrist may be able to advise when a more lucid interval can be expected for a particular patient. In senile persons, for

example, the phenomenon of mental fatigue makes it advisable to execute the will early in the day. Or the psychiatrist may advise postponing execution until another day when the patient may be more lucid.

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Leon Ginsberg, Ph.D.

A Radical View of Social Welfare and Mental Health

The author questions the generally accepted belief that there is a phenomenon that can be called mental illness. He calls for termination of involuntary commitment and urges reforms in the adjudication of incompetence and the internal functioning of mental institutions. Research indicates that involuntary commitment to mental hospitals happens primarily to the poor. Since social welfare professions have come to identify with the poor it would appear incumbent upon them to take immediate steps to reform the operations of mental health systems. Ultimately they should change the nature of the ways in which society deals with those whose behavior it finds unacceptable.

Mental health programs have, to a large extent, escaped the attacks of those who criticize our present social welfare programs. Often the demands for reform of mental health practices are of the sort which infer that although the system itself is both

necessary and sound, it requires certain specific additions to make it succeed. Thus, the typical critique of the mental health programs is that mental health needs more and better social workers, psychiatrists, and psychologists who must practice their professions in less crowded, more adequate facilities in which more public monies are invested each year.

This paper takes a different point of view. It suggests that the practice of denying liberty to American adults who are defined as mentally ill requires re-examination, at least, and, ideally, abolition. It

Dr. Ginsberg is director of the Division of Social Work, College of Human Resources and Education, West Virginia University, Morgantown, W. Va. 26506.

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proposes that because most of what is called mental health treatment is directly associated with involuntary commitment, there is a need for less, not more, mental health funding, facilities, and personnel. It further proposes that if the current mental health practices must continue, there are major reforms required in the involuntary commitment process practices within institutions, and the whole notion of what constitutes mental illness.

A Radical View

The title of this presentation indicates that the author takes a radical view toward mental health programs. This is rooted in the older tradition of radicalism, as Dr. Daniel Boorstin defines it. According to him, there are three distinct, yet inter-related characteristics, which have traditionally been identified with American radicalism:

1. Radicalism is a search for meaning.
2. Radicalism has a specific content.
3. Radicalism is an affirmation of community.¹

It is from these perspectives that reforms of mental health are proposed.

A Search for Meaning

As Boorstin puts it, "When the true radical criticizes society, he demands that the society justify itself according to some new measure of meaning.¹ More and more students of mental health practices are operating from this perspective. Is there such a thing as mental illness, the critics ask, and can it be objectively identified? And if it cannot be, how can society deny physical liberty to those who are alleged to be suffering from it?

Dr. Thomas Szasz, associate professor of psychiatry at the State University of New

York Medical School in Syracuse, has been the leading challenger of most definitions of mental illness. Szasz states his viewpoint with the title of his best-known work, *The Myth of Mental Illness*.² His central idea is that mental illness is simply society's way of defining those whose behavior it considers intolerable. The mental health system that has grown up around that definition operates effectively to isolate from society those who deviate from society's norms.

One who is defined as mentally ill may find himself involuntarily committed for years—perhaps his whole life—to a mental hospital. Even if he is eventually discharged, he may be denied status as a competent person. Within a hospital he may find basic human rights, such as sending and receiving sealed mail, denied to him.

The Involuntary Commitment Process

Central to any discussion of mental health practices is an assessment of the ways in which people become defined as mentally ill. Several researchers have directed their attention to the process through which such definitions are made. This writer's research involved a detailed examination of the commitment process in general and 125 commitment cases in one urban, one rural, and one metropolitan county, in particular. More thorough discussions of those studies have been published elsewhere.³ Some of the general findings follow.

The statutes of most states provide two general bases for involuntary commitment.⁴ These are dangerousness (to oneself or others) and, simply, impaired mental health. Typically, the determination of an alleged mentally ill person's mental health or illness is made by some kind of extra-judicial board. In some states the board has the power to act on its own. In others, it makes

recommendation to a judge, who is responsible for the ultimate disposition of the case.

Generally, the sanity commission or examining board is composed of physicians. In some states, a lawyer serves as a board

The typical involuntary commitment subject is probably very young or very old or very poor or very drunk and is identified as mentally ill by someone who has the power to control him and who finds his behavior offensive.

member. However, his role is not to represent the person alleged to be mentally ill.⁵ Usually his role is to insure the sanity commission and the judge that their decisions are made within the context of the statutes of the state. The physicians and the committing authorities are typically not psychiatrists.

The Diagnostic Process

Frequently, no real diagnosis of the potential patient is made. In the urban county studied by this writer, nearly one-third of the fifty sample cases had no diagnosis. In the metropolitan county studied, all of those who were committed were diagnosed as "psychotic." All of those not committed were called "not psychotic." This was true in spite of a wide variety of descriptions of the potential patient and his situation. When the county judge was asked why these two terms were always used and always had the same consequences, he said that he instructed the examining boards that psychotic meant mentally ill within the framework of the statutes. Thus, if the examining board wanted to commit a person, they had to define him as psychotic. If they did not, the person was free to leave.

Mental health records are, in many jurisdictions, open to anyone who wants to see them. They remain permanently on file in county courts in the state system studied by this writer. Being defined as a "psychotic" and having that term associated with one's name in a public record for the balance of one's life is likely to be equivalent to permanent social and economic ostracism. In the rural county, there was, in one-third of the cases studied, no diagnosis at all.

The Committed Person

One can construct from various research sources a profile of a typical involuntary commitment. The subject is probably very young or very old or very poor or very drunk and is identified as mentally ill by someone who has the power to control him and who finds his behavior offensive. Usually that person is a family member, but occasionally he is a police officer.

The person is taken into custody in a prison, a mental hospital, or a general hospital, and, after some specified period, is "examined." Generally, the examining board hears the case in a matter of minutes, completes some sort of legal document (almost always recommending commitment), and reports to a judge. The judge agrees with the committing authority, places the newly defined mentally ill person in the custody of a law enforcement official, and the "patient" becomes an inmate of a state hospital.

In the process, the potential patient has, as Scheff has demonstrated, scarcely been examined at all.⁶ He is not guaranteed counsel, a right which has been extended to every law violator, whether he is charged with murder or vagrancy, whether he is an adult or a juvenile. He loses his liberty without the normal guarantees of due process.

Statistical analysis of the data on 125 commitment cases studied by this writer indicates that those who are committed represent a special population group. For

. . . the more violent a person appeared to be, the less time he was likely to spend in the mental institution.

example, of the individuals whose cases were studied, only 50 were married. They were less well educated than the average population. That is, the median number of years of education was 9.1, which is less than the average for the nation and for the state where the research was conducted. In terms of religion, most of the persons committed belonged to fundamentalist churches of low social status, according to a sociological classification of religious groups.⁷

Using Hollingshead's occupational ranking scale,⁷ one finds that those who were committed were either employed in or married to people employed in occupational classes in the lowest categories. There were more people in the lowest occupational category than in any of the others. Only ten had any association with the top three occupational categories. Thus, from the educational, religious, and educational data available, it would appear that those who are committed represent the lowest socio-economic classes.

There are several ways to interpret such data. Hollingshead and Redlich⁷ seem to say that the lower socio-economic classes are more vulnerable to severe mental illness. Others insist that it is involuntary commitment to which the lower socio-economic classes are vulnerable. Obviously, the two conclusions do not have the same meaning. Another characteristic that one may infer from some research is that the person who is committed is more docile than those who

are not committed and that the more docile he is, the longer he will remain hospitalized.

This writer's study of 125 commitment cases indicated a negative correlation between the characteristic of violence directed at oneself or others and length of stay in the hospital. That is, the more violent a person appeared to be, the less time he was likely to spend in the mental institution.

Radicalism Has a Specific Content

Radicals want something. It is not enough, the radical believes, to demand change or reform without defining the desired reforms.

It is unlikely that many judges and juries could bring themselves to deny liberty, on criminal grounds, for reasons that routinely lead to a loss of liberty in mental health proceedings. And that is the key point of this paper. No man should lose his liberty unless he has been convicted, through the required procedures, of violating a specific crime. All others should be free to live freely and function freely in a free society.

However, this radical view agrees that there are those who need help with emotional problems. This writer does not condemn the organization and delivery of services which are likely to ameliorate personal psychological suffering, within or without institutions. But all mental health services must be voluntary.

There is much value, one may agree in group and individual counseling for emotional problems. A strong case can be made

People should not be hospitalized for "their own good". Nor should they be threatened with hospitalization if they fail to cooperate with families, policemen, or community mental health authorities.

for the value of mental health orientations for teachers. Mental hospitals also perform a useful service for those who do not choose to function in the larger society. Those who are troubled by marital problems, parent-child conflicts, the loneliness of aging, and the total range of problems currently defined as emotional upset or mental illness need help and should have it available—preferably without charge—in an ideal society.

On the other hand, that help should never be imposed upon anyone. People should not be hospitalized for "their own good". Nor should they be threatened with hospitalization if they fail to cooperate with families, policemen, or community mental health authorities.

Mental Illness and Incompetence Must Be Separated

Another of the specific reforms considered imperative by the radical critics of mental health systems is that the process of declaring people incompetent be radically changed. The issue of incompetence is rarely discussed, yet it stands as one of the most severe abuses faced by those who find themselves defined as mentally ill.

In many states, those who are determined to be mentally ill automatically lose their competence. The consequences of that loss are greater than is generally recognized. For example, those who are declared incompetent may lose their rights to practice their professions, operate a motor vehicle, marry, divorce, defend against divorce, retain custody of their children, vote, serve on juries or execute contracts.

In other states, a specific adjudication of incompetency must be made before a person loses his competence. However, in most states, incompetence is assumed if a person is involuntarily committed to a mental institution. That differentiation

seems to be one of the few values of voluntary admission into mental institutions. Typically, the voluntary patient specifically retains his competence when he enters the hospital.

Restoration of Competence

Also at issue is the manner in which competence is restored. In some jurisdictions of some states, the person is simply restored to competence when he leaves the hospital through a certificate executed by the superintendent of the hospital. In other jurisdictions, a person must go through a complicated legal process to have his competence restored.⁴

... it is unlikely that many judges and juries could bring themselves to deny liberty, on criminal grounds, for reasons that routinely lead to a loss of liberty in mental health proceedings.

Action to withdraw competence should never be taken on the basis of commitment alone, but, when it is, it ought to be restored as easily and as rapidly as possible. More than one discharged mental patient has found himself, years after his hospitalization, faced with an inability to function as a free citizen simply because his competence was never restored.

If involuntary commitment is to continue, there must be basic changes in the way certain elements of hospitalization are handled.

It is true in too many mental hospitals that all patients are treated alike in regard to such basic things as receiving and sending sealed letters, making telephone calls, having access to their property, having a right to choose or not to choose certain undesirable or dangerous treatment such as

electric shock, insulin shock, tranquilizing drugs, physical restraints, and isolation.^{3a}

Patients ought to be allowed to retain as many of their rights as is possible and that determination ought to be made liberally, rather than conservatively. The typical method of handling mail, for example, is for patients to be required to drop their mail unsealed into a mailbox, where it can be censored by an aide. Similarly, the patient's mail is censored before it reaches him. There may be an excuse for such practices in some extreme cases. For the most part, however, such a practice seems both humiliating and unwarranted.

Another typical practice (and there are many others) is for newly arrived patients to be routinely asked to change into either hospital clothing or new clothing that they have brought with them. Their original clothing is then searched for various kinds of contraband.

The purpose of many of these practices seems to be that of demeaning the patient. While extraordinary security precautions are occasionally necessary in any institutional situation, mental hospitals tend to use them routinely.

Affirmation of Community

Borstin's third characteristic of radicalism is an affirmation of community. The radical's affirmation of community implies that all men are bound together in common cause and victims of similar consequences. The diminution of one man's liberty diminishes the liberty of all men.

The social welfare disciplines have taken

positions asserting the need for social reform. Yet it is distressing to note that the social welfare literature includes little on the issue of civil rights and mental illness. It would seem that those in these disciplines should lend their support to reform efforts. Otherwise, social welfare will perpetuate a system which it cannot philosophically accept and which, on the other hand, it would seem philosophically obligated to change.

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Sarnoff A. Mednick, Ph.D.

Breakdown in individuals at high risk for schizophrenia: possible predispositional perinatal factors

Preface

Every now and then the scientific community is intrigued by a research project that seems to promise a good deal more than the average. An example might be Neal Miller's fascinating forays into the conditionability of the autonomic nervous system; or Seymour Kety's massive study of the genetics of schizophrenia. Some of these endeavors end unfinished, essentially irrecoverable. Others manage to end, but become enshrouded by methodological doubts and second thoughts. It is uncommon for an investigator to have the opportunity and the imagination to design and carry out any long-term study that is marked by clarity, methodological sophistication and a certain difficult-to-define elegance of approach. We are taking the somewhat unusual step of highlighting the following paper because it seems to us to be a rather adequate report on just such a rare investigation.

Dr. Mednick took the bold step (which now seems so obvious to those who did not think of it) of studying a population at high risk for schizophrenia—namely, the children of schizophrenic mothers. He is using a prospective approach, that is, a longitudinal study of children in the field, rather than the more usual retrospective approach, which consists in the attempt to elicit meaningful data about the past from the memories of the patients and those around them. This latter approach is fraught with grave methodological dangers, of which the most common is the fallible memory of *Homo sapiens*. Probably the only useful type for a retrospective study is the technique, employed by Ricks and by Robins in their classic studies, which utilizes childhood observations done by experts, with follow-up of the same children in later life. The study reported here, while basically prospective in design, has also made use of this more sophisticated retrospective device for certain kinds of data. Hopefully, Dr. Mednick's work can be replicated on a larger scale, utilizing prospective methods exclusively.

What has he discovered that is so remarkable? First, of course, he has been a pioneer in the high risk prospective method of study, which should earn him, at least, a footnote in textbooks on research methodology; second, (and this should earn him and his colleagues a rather large number of pages in future texts on schizophrenia), he has spelled out in precise detail, though still in a preliminary fashion, what some of the pertinent variables may be in the development of severe behavioral disturbance.

These seem to be, as we have long suspected, in part experiential. It also seems that these experiences do not seem damaging to the psychic homeostasis of the patient unless certain biologic antecedents are present. These antecedents are, secondarily, the autonomic sensitivity described in the accompanying paper, but the primary phenomenon appears to be that, given a genetic predisposition (which probably by itself need not lead to serious behavioral disturbance), the full-blown behavior disorder can only appear if anoxia during the birth process has been part of the history. Dr. Mednick speculates, rather convincingly, that a certain part of the so-called "old brain," the hippocampus, is selectively damaged, leading to the difficulties in condition—ability that seem an essential aspect of the malignant process.

The extraordinary importance of this finding for Mental Health Associations lies in the relevance it has to programs of prevention. There is at least a possibility that our wretched record of perinatal disability can be markedly reduced. If a by-product of such a reduction were a concomitant reduction in the terrible sensitivities and inadequate coping mechanisms that are the essential substrate of schizophrenia, the effort might well become a major program of Mental Health Associations everywhere.

—The Editor

The investigators observed a distinctive premorbid pattern of behavior in a group of adolescents who suffered psychiatric breakdown. This pattern was found to be closely associated with pregnancy and birth complications which could have produced anoxic states likely to damage certain areas of the brain. One such area is the hippocampus. The adolescents who suffered complications exhibit a pattern of behavior analogous to the behavior of rats with surgically-inflicted hippocampal lesions. Neurophysiological and biochemical mechanisms are described which could mediate the hypothesized relationship between a damaged or weakened hippocampus and the pattern of behavior of the breakdown group.

In 1962-63 in Copenhagen, Denmark, Dr. Fini Schulsinger and I intensively examined 207 "normally functioning" children with a high risk of becoming schizophrenic. (They have chronic and severely schizophrenic mothers.) We also examined

104 controls. The study is prospective and longitudinal. We intend to follow these 311 subjects for 20-25 years. During the course of these years we estimate that approximately 100 of the high-risk children will succumb to some form of mental illness, twenty-five to thirty should become schizophrenic.

Dr. Mednick is professor of psychology at the New School for Social Research, 65 Fifth Ave., New York, N.Y., 10003, and Director of the Psykologisk Institut in Copenhagen.

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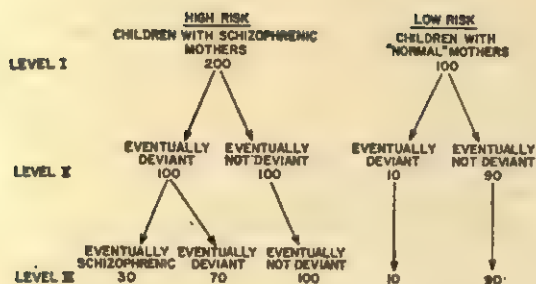


FIG. 1. The design can be conceptualized as developing at three levels. At the first level we can study the distinguishing characteristics of children with schizophrenic mothers in comparison with children with no familial psychiatric background. At the second level we can estimate that about 50% of the high-risk children will become seriously socially deviant. Rather good controls for these deviants are the children with schizophrenic mothers who do not become deviant. At the third level we can estimate that perhaps 30 of the 100 high-risk deviants will be diagnosed schizophrenic. The remaining 70 high-risk deviants may be considered appropriate controls for these 30 schizophrenics, as may the non-deviant, high-risk children and the low-risk children.

Such a study may not be readily or at least easily replicated. Others using even the same design may not be attracted to the same variables. In view of this fact a form of replication can be built into the design. At level II the 100 eventually deviant individuals may be conceived of as suffering breakdown in five waves of 20 subjects each. Thus, there are four potential replications of the first data analysis. (It should be mentioned that the precision of the replication might be attenuated if the waves differ in age of breakdown or diagnosis.) At level III the 30 schizophrenics may be conceived of as suffering breakdown in two waves of 15 subjects each.

Figure 1 presents a schematic picture of the research design of this type of study. There are certain research advantages in the longitudinal study of such high-risk populations.

1. They have not yet experienced many aspects of the schizophrenic life such as hospitalizations and drugs. Thus, these factors do not yet color their reactions.

2. The researchers, relatives, teachers and the subject himself do not know that he will become schizophrenic. This relieves the data of a certain part of the burden of bias. The bias is certainly not greater for the future schizophrenic than for other high-risk subjects who do not succumb.

3. The information we gather is current, not retrospective. That part of our inquiry which is retrospective is less so than it would be if the subjects were adults.

4. The data are uniformly and systematically obtained. This is in contrast to retrospective studies which make use of childhood and school records concerning adult schizophrenics. (A detailed discussion of the high-risk design may be found in Mednick and McNeil).³⁸

Since 1962, 20 of our high-risk children have suffered severe psychiatric breakdown.

I will briefly summarize the 1962 premorbid characteristics that distinctly differentiated these 20 sick children from controls.

Methods

The high- and low-risk samples were matched, individual for individual, for certain variables. (Table 1).

As may be seen, the average age of the sample was 15.1 years (range was 9–20 years). There would have been some advantage in testing a younger group; however, it will take 20–25 years for the present sample to pass through the major risk period for schizophrenia. The subjects' mean age was selected so as to maximize the probability that the investigators would still be alive at the conclusion of this risk period. Studies of three-year-old and ten-year-old high-risk

samples are being undertaken. A study of prenatal high-risk children is being planned.

Procedures

In addition to weight and height the following measures were taken in the intensive 1962 examination:

1. **Physiological-conditioning-extinction testing.** Continuous recording was made of heart rate, muscle tension, respiration, and galvanic skin response (GSR) during rest, conditioning, generalization and extinction procedures. The CS was a 54 db tone of 1000 cps. The UCS (also considered the stress stimulus) was a very irritating, loud (96 db) noise presented via earphones.

TABLE 1

Characteristics of the Experimental and Control Samples

	Control	Experimental
Number of cases	104	207
Number of boys	59	121
Number of girls	45	86
Mean age §	15.1	15.1
Mean social class †	2.3	2.2
Mean years education	7.3	7.0
Per cent of group in children's homes (5 years or more) £	14%	16%
Mean number of years in children's homes (5 years or more) £	8.5	9.4
Per cent of group with rural residence ø	22%	26%

§ Defined as age to the nearest whole year.

† The scale runs from 0 (low) to 6 (high) and was adapted from Svalastoga (1959).

£ We only considered experience in children's homes of 5 years or greater duration. Many of the Experimental children had been to children's homes for brief periods while their mothers were hospitalized. These experiences were seen as quite different from the experience of children who actually had to make a children's home their home until they could go out and earn their own living.

ø A rural residence was defined as living in a town with a population of 2500 persons or fewer.

2. **Wechsler Intelligence Scale for Children.** (Danish adaptation). All subtests were administered.

3. **Personality Inventory.** This consisted of a group of items translated from the MMPI.

4. **Word Association Test.** This was a translation of the Kent-Rosanoff list.

5. **Continuous Association Test.** We observed the flow of the subject's associations to a single word over a one-minute period. Thirty stimulus words were used.

6. **Adjective Check List.** A list of 241 items was used by professional personnel to describe the subject. The subject also described himself using the same list.

7. **Psychiatric Interview.** A pre-coded psychiatric interview was included for diagnostic purposes and to elicit reports from the subject on his current social and interpersonal functioning. A rating of Level of Adjustment was made for each subject.

8. **Parent Interview.** A pre-coded interview was conducted with the individual with major responsibility for the child's rearing.

9. **School Report.** A questionnaire was obtained from the teacher that knew each subject best.

10. **Midwife's Report.** This is a detailed, legally required, standard form prepared by the midwife attending the subjects birth.

More detailed statements of methodology may be found in Mednick and Schul-singer.^{20, 30, 31}

Results

As of last year, the first wave of 20 breakdowns (which we call the Sick Group) had been identified. Their clinical status is described very briefly in Table 2. Thirteen have been admitted to psychiatric hospitals with many diagnoses including schizophrenia. The seven not admitted include some

TABLE 2

Descriptions of Conditions of Sick Group

1. Male, born 16 March 1953. Extremely withdrawn, no close contacts, 2 months' psychiatric admission following theft, currently in institution for boys with behavior difficulties, still performing petty thievery.
2. Female, born 19 January 1943. Married, one child, extremely withdrawn, nervous. Evidence of delusional thinking, pulls her hair out, has large bald area.
3. Female, born 29 March 1946. Promiscuous, highly unstable in work, no close contacts, confused and unrealistic, psychiatric admission for diagnostic reasons, recent abortion, some evidence of thought disorder.
4. Male, born 1 July 1946. Under minor provocation had semipsychotic breakdown in Army, expresses strange distortions of his body image, thought processes vague, immature.
5. Male, born 2 May 1944. Severe difficulties in concentrating, cannot complete tasks, marked schizoid character, marginally adjusted.
6. Male, born 3 June 1947. Lonely in the extreme, spends all spare time at home. Manages at home only by virtue of extremely compulsive routines. No heterosexual activity, marked schizoid character.
7. Male, born 1 October 1953. No close contact with peers, attends class for retarded children, abuses younger children, recently took a little boy out in the forest, undressed him, urinated on him and his clothes, and sent him home.
8. Male, born 17 January 1954. Has history of convulsions, constantly takes antiseizure drug (Dilantin), nervous, confabulating, unhappy, sees frightening "nightmares" during the day, afraid of going to sleep because of nightmares and fear that people are watching through the window, feels teacher punishes him unjustly.
9. Female, born 18 March 1944. Nervous, quick mood changes, body image distortions, passive, resigned. Psychiatric admission, paranoid tendencies revealed, vague train of thought.
10. Male, born 14 March 1952. Arrested for involvement in theft of motorbike. Extremely withdrawn, difficulties in concentration, passive, disinterested, father objected to his being institutionalized, consequently he is now out under psychiatric supervision.
11. Male, born 19 October 1947. Level of intellectual performance in apprenticeship decreasing, private life extremely disorderly, abreacts through alcoholism.
12. Male, born 20 January 1944. Severe schizoid character, no heterosexual activity, lives an immature, shy, anhedonic life, thought disturbances revealed in TAT.
13. Female, born 25 May 1947. Psychiatric admission, abortion, hospital report suspect pseudo-neurotic or early schizophrenia, association test betrays thought disturbance, tense, guarded, ambivalent. Current difficulties somewhat precipitated by sudden death of boy friend.
14. Male, born 13 August 1950. Sensitive, negativistic, unrealistic. Recently stopped working and was referred to a youth guidance clinic for evaluation. Is now under regular supervision of a psychologist.
15. Male, born 28 May 1947. History of car stealing, unstable, drifting, unemployed, sensitive, easily hurt, one year institutionalization in a reformatory for the worst delinquents in Denmark.
16. Female, born 1 June 1945. Psychotic episode, one year of hospitalization. Diagnoses from 2 hospitals: (1) schizophrenia, (2) manic psychosis.
17. Male, born 3 September 1946. Severe schizoid character, psychotic breakdown in Army, preceded by arrest for car thievery. Now hospitalized.
18. Male, born 28 January 1953. Perhaps border-line retarded. Psychiatric admission for diagnostic reasons, spells of uncontrolled behavior.
19. Male, born 23 June 1948. Repeatedly apprehended for stealing, severe mood swings, sensitive, restless, unrealistic, fired from job because of financial irregularities.
20. Female, born 5 July 1941. Highly intelligent girl with mystical interests. Very much afflicted by mother's schizophrenia. TAT reveals thought disorder. Receiving psychotherapy.

who are clearly schizophrenic. The clinical status of these individuals was ascertained by our follow-up procedures. To each of these 20 we have matched another high-risk subject (Well Group) of the same age, sex, social class, and institutional rearing status. In addition we have matched these subjects

for the psychiatrist's 1962 Level of Adjustment rating. We tried as much as possible to select individuals for the Well Group who, since 1962, had shown some improvement in Level of Adjustment. Also, 20 Controls were selected from the low-risk group for comparison purposes. This matching

yielded two groups of high-risk subjects. In 1962, both were judged to be equal in Level of Adjustment. Yet since 1962 one group has improved in level of mental health, the other group has suffered severe psychiatric breakdown. Why? Part of the answer could lie with the predisposing characteristics measured in 1962 at the time of the intensive examination.

The most important characteristics distinguishing the Sick Group from the Well and Control Group were:

1. The Sick Group lost their schizophrenic mother to psychiatric hospitalization much earlier in their lives than did the other two groups. These early-hospitalized mothers were also more severely schizophrenic. The Well Group lost their mothers at approximately the same time as did the Control Group. In view of the greater severity of illness of the mothers who left their home early, these data may be interpreted in relatively genetic or environmental terms.

2. The teachers' reports indicate that the Sick subjects tended to be disturbing to the class. They were disciplinary problems, domineering, aggressive, created conflicts and disrupted the class with their talking. This was true of 53% of the Sick Group, 18% of the Well Group, and 11% of the Control Group.

3. On the Continual Association Test, where the subject is asked to give, in one minute, as many single-word associations as he can to a stimulus word, the Sick Group showed two distinctive patterns. They had a strong tendency to rattle off a whole series of words which were interrelated but contextually relatively irrelevant, "Opremsning", in Danish. Their associations also tended to "drift" away from the stimulus word. Contrary to instructions and cautions they might begin responding to their

own responses; for example to the stimulus word "Table" they might respond "Chair, top, leg, girl, pretty, sky . . ." Those in the Sick Group who do not evidence drifting can apparently manage to avoid this only by restricting themselves to one or two responses per stimulus word for the entire one-minute period.

4. Some of the variables most sharply differentiating the Sick Group from the Well and Control Groups were the electrodermal measures taken during the psychophysiological testing. These measures largely reflect the functioning of the body's stress mobilization mechanisms.

- a) The latency of the GSR was substantially faster for the Sick Group than for either of the other two groups.

- b) The GSR latency for the Sick Group did not show any signs of habituation. This was especially marked in their responses to the nine UCS stress stimulus trials. The Control and Well Groups' rapid habituation of latency was seen in the progressive increase of their response latencies from the first to the last of the stress trials. The latencies of the Sick Group progressively decrease suggesting a negative habituation or even increasing irritability. Moving from UCS trials I-IX, 69% of the Well Group exhibit a slowing of response latency (habituation); 75% of the Sick Group actually increase the speed of their response.

- c) A well-documented characteristic of conditioned GSR behavior is the rapidity with which it demonstrates experimental extinction and/or adaptation. In both the Well and Control Groups electrodermal responsiveness was already dropping off by the end of the stress stimulus trials. Following those stress trials we presented a series of nine nonreinforced test trials for generalization and speed of extinction of the conditioned response. The Well and Control Groups evidenced very rapid extinction,

i.e. they responded to only one or two of the extinction test trials. The Sick Group exhibited great resistance to extinction, in many cases responding with tenacity until the very end of the extinction series.

d) The Sick Group showed remarkably fast recovery from momentary states of autonomic imbalance. Once a GSR was made we measured the rate at which recovery to basal level proceeded. (This measure and its theoretical significance has been reported previously in this Journal²⁸.) On some trials rate of recovery almost perfectly separated the Sick and Control Groups. The pooled Sick and Well Groups' distributions for rate of recovery typically found 70% of the Sick and 30% of the Well Group above the median.

The above material may be found discussed in greater detail in Mednick and Schulsinger³¹.

5. In a previous report of the differences between the Sick, Well and Control Groups we pointed out that while in our analyses of data on birth complications "there was a slight general tendency for the Sick Group to have had a more difficult birth, none of the differences reached statistical significance"³¹. Subsequent, more careful, examination of these data revealed that while it was true that no single complication significantly differentiated the groups, 70% of the members of the Sick Group had suffered one or more serious pregnancy or birth complication (PBC). This contrasted sharply with the 15% of the Well Group and 33% of the Control Group with PBCs. The PBCs included anoxia, prematurity, prolonged labor, placental difficulty, umbilical cord complication, mother's illness during pregnancy, multiple births, and breech presentations. Careful perusal of these data brought out an additional striking relationship within the Sick Group (and the entire high-risk group). There is a

marked correspondence between PBC and the anomalous electrodermal behavior reported above. All the GSR differences between the Sick and Well Groups could be explained by the PBCs in the Sick Group. In the Control Group and low-risk group the PBCs were not strongly associated with these extreme GSR effects. This suggests that the PBCs trigger some characteristic which may be genetically predisposed. The PBCs seem to damage the modulatory control of the body's stress-response mechanisms. PBCs are associated with rapid response onset, poor habituation of the response, poor extinction of the conditioned electrodermal response, and very rapid recovery from the response. In terms of the theoretical orientation guiding this project (Mednick,^{27, 28, 32}) this lack of modulation may be viewed as an important etiological factor in the development of mental illness, especially schizophrenia.

The finding that immediately raised fertile questions was the high frequency of PBCs in the Sick Group. What damage might these PBCs have done and where? We first sought for inklings of brain sites particularly sensitive to being damaged by PBCs. We then examined animal studies in which analogous damage had been inflicted by surgical lesion to particularly sensitive brain sites. The reports of the behavior of animals suffering surgically inflicted lesions to these same areas were then searched for instances of behavior similar to that which we observed in our PBC-Sick subjects. We hoped in this manner to generate hypotheses regarding specific sites of brain lesions in our PBC subjects.

Brain Sites of Selective Vulnerability

PBCs result in future difficulties for the fetus chiefly because of the great sensitivity

of neural tissue to anoxia. (Mechanical damage probably plays a less significant role, although through vascular obstruction it can also lead to anoxia.) Researchers have singled out particular brain structures as being "selectively vulnerable" to the effects of anoxia. These areas include most prominently, the hippocampus, and Purkinje cells of the cerebellum.² Of these two areas, Spector⁴⁶ singles out the hippocampus as being the most vulnerable. He evaluates the effects of anoxia by studying "biochemical lesions", i.e. "the initial chemical changes in tissues following the application of harmful agents and preceding anatomical evidence of damage". The chemical changes he has studied as a function of anoxia have been losses in certain enzymes which precede "histological evidence of cell injury by approximately 10 hours. It is noteworthy that chemical changes appear in the hippocampus immediately after anoxia, whilst the other areas show earliest loss of enzymes after 1-6 hours. The enzyme loss in the hippocampus involved the neurones and was not apparent in the glia or neuropil. This observation suggests that, in this site at least, the neurones are more susceptible than are the surrounding cells to oxygen lack" (552-553).

Friede¹² also indicates that the hippocampus (Ammons Horn) represents one of "the most striking examples of selective vulnerability in the brain and in particular Sommer's Sector, H 1 is known to be a characteristic site for anoxic damage". (Friede links this vulnerability of H 1 to relatively low levels of lactate dehydrogenase in Sommer's Sector).

Animal Ablation Literature

Thus, with the hippocampus as our chief, and most likely suspect, and the amygdaloid and the cerebellum (Purkinje cells) as an

additional suspect we next turned to the animal ablation literature. The strategy here was to see if we could find any similarity between the behavior of our Sick subjects with PBCs and the behavior of animals with circumscribed lesions to each of these suspect areas. Conditioning and extinction behaviors are frequent dependent variables in animal ablation studies. This facilitated comparisons with our data since our subjects have gone through a conditioning and extinction session.

Briefly stated, the literature on the Purkinje cells did not strongly relate to the conditioning data of our PBC subjects. On the other hand the behavior of hippocampal animals was in some surprising ways like that of our PBC-Sick subjects. At this point we must sound a strong note of caution; below we will be relating rat, instrumental, and human, classical conditioning data. It is doubtless a questionable procedure to draw analogies across two species and two types of conditioning. In this case it has proven of great value for hypothesis formation. These ideas are presented in this spirit.

There are several aspects of the behavior of hippocampal rats which are of interest to us in the present context.

1. Rats with hippocampal lesions manifest relatively fast response latency^{19, 41, 45}.

2. Rats with hippocampal lesions evidence very poor habituation of the latency of their responses. While normal and cortically damaged control groups exhibit habituation by responding with increasing latencies across a series of test trials, the response latencies of the hippocampal rats do not slow down. They continue to respond as though they were experiencing the stimulus for the first time¹⁷.

3. Rats with hippocampal lesions evidence great resistance to the experimental extinction of conditioned behavior^{15, 37}.

4. Rats with hippocampal lesions are hyperactive^{16, 45}.

5. Rats with hippocampal lesions acquire a conditioned avoidance response in a shuttle box more quickly than control or cortically damaged rats^{15, 18, 45}.

In comparing these characteristics with the characteristics described above for the Sick Group we can detect some considerable similarity. Both the Sick subjects with PBCs and the hippocampal rats evidence fast response latency, very poor habituation and poor extinction of a conditioned response. We can also tentatively link the hyperactivity of the hippocampal rats to the unruly classroom behavior of our Sick Subjects. The two points that do not immediately relate to each other are the fast avoidance conditioning of the hippocampal rats and the fast GSR recovery of the Sick Group with PBCs. In terms of some of the components of a theory of schizophrenia advanced earlier^{31, 32} these seemingly independent points may actually be closely related. Thus, if we assume that the fast GSR recovery of the Sick Group with PBCs is also characteristic of the hippocampal rats we can postulate some basis for the puzzling and consistent finding of unusually fast avoidance learning on the part of the hippocampal rats. Whether one takes a reinforcement or contiguity position, one crucial variable influencing speed of avoidance conditioning in a shuttle box is the rapidity and amount of fear reduction following a successful avoidance response. After the avoidance response has been made, the speed and the amount of reinforcement depends in large part, on the speed of fear reduction and hence on the rate of recovery from the stress response⁵⁷. Any rat who recovers unusually rapidly from a stress response will receive a correspondingly rapid reward of fear reduction when he leaps from the shuttle box' electri-

fied grid floor into the safe compartment. His reinforcement will be greater than that of a rat with normal recovery rate or slow recovery rate. Fast recovery from stress response could conceivably explain the otherwise rather mysterious rapid avoidance learning of hippocampal rats. If such fast recovery were directly demonstrated, the similarity of hippocampal rats to our PBC-Sick subjects would be striking. In the light of the sensitivity of the human hippocampus to the anoxic effects of PBCs, this similarity would suggest the hypothesis that the PBCs in our high-risk children have resulted in damage to their hippocampus. What is further suggested is the possibility that the resultant behavioral anomalies are in some way predispositional to psychiatric breakdown and schizophrenia in individuals with schizophrenic mothers.

Implications

In summary:

1. The most likely site of brain damage resulting from PBCs seems to be the hippocampus, especially Sommer's Sector, H 1.
2. High-risk children who have suffered PBCs exhibit a specific and unique pattern of conditioning, habituation, extinction and GSR behavior. (This pattern is also exhibited by low-risk children with PBCs but at a diminished level).
3. This pattern is strikingly similar to the conditioning, habituation and extinction behavior of rats who have experienced surgical lesions to the hippocampus. These surgical lesions encompass what in the human would be Sommer's Sector H 1.¹⁹

Another important aspect of behavior which is characteristic of hippocampal rats has been observed in infants who may have suffered anoxia and hence hippocampal damage at birth. Kimble¹⁷ indicates that "damage to the hippocampus should impair the process of habituation to novel

stimuli, as has been reported (Leaton, 1965)". This same failure of habituation to novel stimuli has been reported for infants at the ages of two days, five days and 30 days in those cases where the mother had undergone heavy anaesthesia during delivery. Controls were infants of the same age where the mothers had undergone mild or no anaesthesia.⁶ Maternal heavy anaesthesia during delivery can effect the fetus, producing retarded respiration and anoxia.³⁸ In the context of this general discussion it is tempting to postulate that in this study anaesthesia-induced anoxia produced some hippocampal damage in these children which, in turn, manifested itself in the form of a failure of habituation.

We are suggesting the existence of a relationship between a pattern of observed habituation-conditioning-extinction findings in our PBC-Sick Group and hypothesized hippocampal damage. It is tempting to consider what biochemical and neurophysiological mechanisms could possibly be at the basis of this hypothesized relationship. One interesting lead is recent evidence of a link between hippocampal functioning and ACTH secretion. Damage to the hippocampus has been shown to result in a failure of inhibition of ACTH released by the pituitary gland.^{20, 21} Weiss, McEwen and DeSilva (personal communication) have evidence that this inhibitory influence is only called into play during states of stress reaction. During such stress states a damaged hippocampus does not provide an adequate inhibitory influence on the pituitary gland and thus permits an oversecretion of ACTH. Interestingly enough, such ACTH oversecretion may be expected to prolong the extinction of a conditioned response.^{7, 8, 9} Such prolonged extinction effects were, of course, observed in our PBC-Sick subjects and are observed in hippocampal rats. It may be suggested that one

basis for this failure of extinction was an oversupply of circulating ACTH due to the failure of a damaged hippocampus to sufficiently inhibit ACTH-pituitary secretion during the stressful psychophysiological session.

This failure to inhibit ACTH secretion because of hippocampal inadequacy may also partially explain the state of hyperarousal that seems characteristic of the schizophrenic.^{1, 5, 14, 25, 35, 42, 52, 53, 56} The explanation of the state of hyperarousal may also follow a relatively non-biochemical, neurophysiological route. On the basis of a series of studies observing cortically evoked potentials to visual and auditory stimuli, while concurrently stimulating the hippocampus, Redding⁴³ concluded that the hippocampus exerts an inhibitory influence on the brain stem reticular formation. An inadequate hippocampus exerting a less than normal inhibitory influence on the reticular formation could contribute to the existence of a chronic state of hyperarousal in an individual. Mechanisms by means of which this hyperarousal and fast GSR recovery and latency could translate themselves into the clinical symptoms and life condition of schizophrenia have been elaborated in detail in earlier publications including this Journal and need not be repeated here^{27, 28, 31, 32}.

We are, perhaps, now at a point where we can hypothesize that PBC factors lead to defective hippocampal functioning which in combination with genetic and environmental factors could conceivably play a vital predispositional role in at least some forms of schizophrenia. This linking of hippocampal functioning and schizophrenia is not an entirely new idea. Necrosis of neural tissue in Sommer's Sector of the hippocampus has been very regularly found in neuropathological studies of the epileptic.³ Chapman³ and Slater, Beard and Glith-

ero⁴⁷ among others have pointed to the great similarity of epileptic states of consciousness, especially psychomotor epilepsy, to the disturbances of consciousness in the schizophrenic. Roberts⁴⁴ conceptualized schizophrenia "as a disordering of an entire brain system . . . correlated with malfunction in the dorsal hippocampal limbic system." There has also been a considerable amount of research linking PBCs with serious behavioral disturbances and schizophrenia in children^{22, 39, 40, 50} and adults.^{28, 49} There are studies in the literature which have demonstrated "typical" hippocampal-lesion behavior in the schizophrenic. Milstein, Stevens and Sachdev³⁴ demonstrated very poor habituation and very fast latency of the alpha attenuation response for chronic adult schizophrenics. As early as 1937, Cohen and Patterson reported poor habituation of the cardiac response in schizophrenics. Zahn⁵⁶ has reported poor habituation of the GSR in chronic schizophrenics. Vinogradova⁵⁵ has demonstrated that chronic schizophrenics take an unusually large number of trials to extinguish a conditioned plethysmograph response.

The adjective "chronic" has been used above to modify the noun "schizophrenia". It may well be that hippocampal dysfunction is an important contributing predispositional factor in only some types of schizophrenia. These may be the more typical, process, chronic, or poor premorbid types. Our Sick subjects tend to be "early onset" cases suggesting that many of them may have a relatively poor prognosis. It is also possible that degree of hippocampal dysfunction will relate to degree of seriousness of illness.

The emphasis on neurophysiological, biochemical and traumatic variables and materials in this paper should not be read as a denigration of the capability of genetic forces to produce identical hippocampal

insufficiency or a disregard for the necessity of an appropriate environment to cultivate the learning of schizophrenic modes of behavior and thought. The emphasis on PBCs should not be read as denying the possibility that postnatal injury or high fever could also produce similar brain damage. Finally we have dealt exclusively with the possible impact of hippocampal injury. We could have also brought the septum and other limbic areas into the discussion. The functioning of the entire temporal lobe is also not irrelevant in this area. However, for reasons that are made evident above, the hippocampus seems the best candidate for our attention.

Implications for Future Study

In terms of the theoretical orientation of the author, the condition of schizophrenia (predisposed by a variety of conditions and circumstances) is a pattern of well-learned avoidance responses. In terms of treatment considerations, such well-learned avoidance responses are difficult to extinguish. Every time an avoidance response is successfully made it is automatically and immediately reinforced. In animal research a shuttle-box-avoidance response can be extinguished by physically preventing the rat or dog from performing the avoidance response in the presence of the avoidance stimulus and not delivering the punishment. However, the bulk of the schizophrenics' avoidance responses are thoughts. These are difficult if not truly impossible to prevent or control. Thus, for theoretical as well as practical and humane reasons our research thinking centers on primary prevention rather than treatment. In view of our findings, one potentially useful field of intervention that suggests itself is the pregnancy and birth process. If a sound hippocampus is a prerequisite for sound mental health and if we can avoid PBCs in high-risk populations,

we may avert hippocampal damage and hence reduce the probability of mental illness. A research project on this very matter is currently being planned. Secondly, in view of the possible involvement of poorly modulated hormonal secretions, research on psychopharmacological intervention at an early premorbid age would seem indicated. Such a study is now in its early stages. We are also conducting further prospective studies on the longterm consequences of PBCs in children with schizophrenic parents.

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William B. Eddy, Ph.D.

Sandra M. Paap, M.Ed.

Donald D. Glad, Ph.D.

Solving Problems in Living: the Citizen's Viewpoint

This study explores the significant problems which citizens encounter in their lives, the way they view these problems, the sources of assistance they seek, if any, and their attitudes about help-providing persons and agencies. Findings point up the important roles played by many persons who are not professionals in the mental health field, but who, nevertheless, provide assistance to others in solving difficult problems of living. Results of the study also indicate that citizens' decisions about seeking help are based on a variety of considerations including familiarity with available services and the way they define their problems.

Introduction

Problems in living may, in certain circumstances, bring the individual under the care of professionals in the field of mental health—in which case the problems are conceptualized as "mental health" or "psychiatric" problems. Under other circumstances, other sources of assistance may be utilized,

or the individual may deal with his own problems as best he can. In these latter cases, concepts related to the field of mental health may never be invoked. Yet it is important in understanding the total picture of community mental health to take into account the spectrum of problems and attempted solutions—regardless of how they are defined.

At the time this study was conducted, the authors were on the staff of the Greater Kansas City Mental Health Foundation. Dr. Eddy is now professor, School of Administration, University of Missouri-Kansas City, 5347 Rockhill Rd., Kansas City, Mo. 64110. Dr. Glad is professor and Director of Clinical Training, Department of Psychology, Louisiana State University. Mrs. Paap lives in Milwaukee, Wisc.

The research reported herein deals with the experiences of citizens of a large metropolitan community in facing the significant problems in their lives—including, but not limited to, problems generally placed in the category of "mental health" problems. The study is concerned with the kinds of problems people have, the ways they view these

problems and respond to them, and the assistance they seek and receive in solving them. Emphasis is upon the development of a description of events as they are seen by citizens and an understanding of the naturalistic processes as they occur. A major purpose of the study was to provide insight into the current and potential utilization of a variety of indigenous community resources in helping people deal with problems.

Method

Structured interviews were held with a sample of one hundred adult citizens of a metropolitan community. The interview schedule, which was extensively pre-tested and revised, elicited, in addition to biographical data, material regarding personal problems, conceptualization of these problems, and ways of dealing with them. At-

titudes toward professionals and community agencies were also obtained.

Great care was taken to avoid any mention of mental illness, psychiatry, mental hospital, or other terms associated with the field of mental health in the introductory remarks or early questions. This step was intended to minimize the possibility of subjects responding with a set toward the professional mental health field, rather than from their own perceptions and experiences regarding problems in living. The study was sponsored by an institution not associated with psychiatric treatment.

A random sample stratified by income levels was drawn from the community, utilizing census data and citizen directories. Alternative subjects were used when members of the original sample could not be interviewed. The final sample appears to be somewhat over-represented (as compared with the community population) in the di-

TABLE 1

Citizen Concerns

Problem Area	Subjects' Own Personal Concerns	Subjects' Perceived Concerns of Relatives and Friends
	Frequency Mentioned	
1. No problems mentioned	14	22
2. Concern about broad social problems—world crises, poverty, sin, crime, etc.	29	7
3. Concern about specific individuals whose problems may affect the subject—alcoholic husband, problem children, etc.	31	22
4. Personal problems, but not psychological—health, financial, work	50	53
5. Interpersonal—getting along with spouse, boss, etc.	3	9
6. Feelings—depressed, nervous, anxious	7	6
7. Serious emotional or behavioral problems	0	4
8. Moralistic judgment of others' behavior—sinful, social striving, lazy, etc.	*	9
9. Respondent refused to "meddle" in "others'" problems	*	3

* Not applicable.

Note: In this and following tables, total responses may equal more than 100 because some subjects mentioned more than one problem.

rection of older married women in lower income categories. This is partly a function of who could be located during the interviewing period.

Results

Subjects were asked early in the interview to mention "the kinds of things that trouble them or cause them the most concern." Interviewers were specifically instructed to avoid inquiring in the direction of mental health problems but, rather, to record those concerns mentioned by the subject in response to the rather general question. In a later question respondents were asked to give their impressions of the kinds of things which cause their close friends and relatives the most concern. Table 1 shows the distribution across coding categories of responses to both questions.

Thus, a sizable majority of the subjects reported being troubled or concerned about something. Relatively few reported themselves as having problems of personal adjustment.

It could be suggested that strong expression of concern about social problems, other individuals, and health problems may be indicative of underlying psychological problems on the part of the respondent. In addition to the possibility of significant

anxiety, concern about social issues such as sin and crime may be associated with depressive and schizophrenic patterns, while concern about physical plights in living may suggest somatization reactions. For the present study, however, one of the significant meanings of the data in Table 1 is that expression of personal concerns outside the mental health setting is usually linked to concrete persons and events.

It may be inferred from Table 1 that people communicate with associates more freely regarding their concerns about matters of finance, personal and family health than they do about social concerns. Frequencies of concern mentioned are generally similar except for category number two in which respondents saw themselves being more concerned than others about social issues.

There is a slightly higher proportion of responses in categories five through eight suggesting some tendency for respondents to view others' problems as more psychologically based than their own. A further exploration of the personality meanings of the kinds of problems subjects projected upon others might allow a different kind of interpretation of these data.

A question with specific "mental health" emphasis was asked later in the interview.

TABLE 2
Acquaintance With Mental Health Problems

a) Has friend or relative had a mental health problem?	Yes	56
	No	42
	No response	2
b) Immediate family or close friend		23
Distant relative or acquaintance		28
Not specified		5
c) Type of help sought		
Mental health professional or institution		35
Other person or agency (M.D., minister, etc.)		10
None		7
Don't know or no response		4

This made possible a comparison of "problems in living" versus mental health or emotional problems experienced by friends and relatives. The question was "Has a friend or relative had a mental health problem?" Table 2 contains a categorization of responses to this item.

Although subjects mentioned mental health problems infrequently in reaction to the general "problems in living", Table 2 indicates that more than half the subjects have in fact experienced mental health problems among friends or relatives. The high frequency with which the identified friend or relative was known to have sought professional assistance may indicate that one of the major identifying factors in labeling a person as mentally ill is his act of seeking professional help. The data suggest that some individuals differentiate concrete problems in living from mental health problems largely on the basis of the labeling that takes place when a person seeks professional help.

Helping Resources

Table 3 shows a listing of all persons and organizations mentioned by subjects as being valuable sources of assistance in problems of living. These responses were gathered from several questionnaire items.

The listings are arranged arbitrarily into general divisions and categories for easier reading. Individuals and agencies are listed by general vocational areas ("a physician") and those specifically named ("Dr. Doe"). There were 787 responses mentioning helping resources in 76 categories. Table 4 shows a ranking of the 16 most often mentioned categories.

The data bear out previous findings,^{1,2} that clergymen and physicians are important sources of assistance. However, when questions are framed in terms other than

specific mental health problems, other groups, whose functions are not seen as psychiatric but who are crucial in solving problems, are mentioned frequently. These groups, including family and friends, welfare and pension agencies, general hospitals, marriage counselors, charities and labor unions, apparently play a significant role in dealing with situations which are, or may become causes of disturbance.

Some resources infrequently mentioned bear discussion. For example, although family members are mentioned most often as sources of help, only two of 86 responses specifically mention father. These data raise some interesting questions regarding family role perceptions and expectations. Another infrequently mentioned category is the work group—co-workers and supervisors. Apparently those individuals with whom an employee is likely to spend a majority of his daylight hours are not frequently seen as helpful in solving problems.

Near the end of the questionnaire, subjects were asked to rate 27 specific community individuals and agencies as "very helpful", "somewhat helpful" or "not helpful" in dealing with personal problems. Table 5 shows the mean rating for each of the resources and also the number of subjects who were unfamiliar with or uncertain about the value of each.

Comparison of Tables 3 and 5 suggests that some resources which are most often mentioned as possible sources of assistance are not rated as potentially helpful as other less often suggested resources. Likewise, resources rated as quite helpful are not often suggested. For example, social workers, teachers and principals, and counselors are relatively infrequently mentioned, but highly rated. Psychiatrists, hospitals and family counselors are frequently mentioned but seen as less helpful than some others. Some resources, for example, physicians,

TABLE 3

*Sources of Assistance Mentioned by Subjects As
Useful in Dealing With Problems*

<i>PROFESSIONAL MENTAL HEALTH</i>	<i>No.</i>	<i>FAMILY AND FRIENDS</i>	<i>No.</i>
Mental Health Center or Hospital	28	Wife	19
Psychiatrist	40	Husband	22
Group Therapy	2	Mother	16
Psychologist	4	Father	2
Social Worker	3	Parents	4
Counselor	7	Family	29
Psychological Tests	2	Friends	28
		Neighbors	8
<i>MEDICAL</i>		<i>OTHER SOCIAL AGENCIES & INSTITUTIONS</i>	
Physician, M.D.	62	Homes for children & adolescents	7
Chiropractor	1	Facilities for physically handicapped & retarded	
Nurse	3	—rehabilitation	4
Hospital—general	60	Correctional institutions	4
County Health Department	1	Family & childrens services, marriage counselors	38
Medical Society	1	Charitable organizations (Salvation Army, etc.)	36
<i>PUBLIC EDUCATION</i>		Facilities & homes for the aging	12
Teacher	6	Welfare & pension (funds & agencies)	61
Principal	3	Miscellaneous agencies with unique functions	11
P.T.A.	4	Labor unions (work problems)	24
Dean's Office	1		
School Counselor	1	<i>COMMUNICATIONS MEDIA</i>	
Board of Education	1	Yellow Pages	9
College Club	1	Newspaper	1
High School Loan Fund	1	Columnist	1
School (general category)	4	Radio Program	1
<i>RELIGIOUS</i>		<i>MISCELLANEOUS PROFESSIONS & OCCUPATIONS</i>	
Clergyman (minister, priest, rabbi)	64	Hospital Volunteers	1
Lay Workers	17	Hypnotist	1
Church	24	Scout Master	1
Spiritual—Bible, prayer	39	Research Scientist	1
<i>GOVERNMENT, REGULATORY</i>		Lawyer	12
City Hall	6	Banker	1
Court House	1	School Crossing Guard	1
Courts—adult	5	Fellow Employees	4
Courts—juvenile	4	Manager	1
Probation Officers	3	Bartender	1
Police	17	Lecturer on Family Life	1
"Authorities"	5	Philanthropic People	1
"Juvenile Authorities"	3		
Veterans' Administration	1		
Federal Housing	1		
Federal Government	2		
State Government	3		
County Government	4		
Army	1		

clergymen and welfare agencies are frequently mentioned and rated as more helpful.

TABLE 4

Summary of Helping Persons and Institutions Most Often Mentioned, With Some Categories Combined

Category	Frequency
Family	86
Clergyman	68
Physician	62
Welfare or Pension Agency	61
Hospital—general	60
Psychiatrist	40
Spiritual Support	39
Family Service—Marriage Counselor	38
Charitable Organizations	36
Friend	28
Mental Health Center or Hospital	28
Union	24
Church Lay Worker	17
Police	17
School Personnel	12
Lawyer	12

Table 6 illustrates the relationships between frequency of mention and rated helpfulness for some of the resources.

In interpreting Table 6 it should be kept in mind that the frequency with which certain resources were mentioned is strongly related to the kinds of problems referred to by the subjects in the course of questioning. Thus, the variable "frequency of mention" must be viewed in part as a question of the specificity or generality of the problems dealt with by the resource person and his social visibility. This hypothesis is supported in Table 6 where it is apparent that being often referred to as a source of possible help is not necessarily the same thing as being seen as potentially most helpful.

The functions of some groups, such as judges, psychologists, counselors and personnel directors, are apparently less socially visible in view of the larger numbers of "no opinion" or "uncertain" responses shown in Table 5. There is a rank-order correlation of $-.35$ between mean degree of perceived helpfulness and number of "no opinion" or "uncertain" responses for resources listed. Although this correlation does not reach statistical significance, it suggests a possible

TABLE 5

Perceived Helpfulness and Degree of Unfamiliarity With Selected Community Resources

Source of Assistance	Mean Rating	No Opinion or Uncertain
Doctor or Physician	3.91*	2
Social Worker	3.90	8
Clergyman	3.89	0
Teacher or Principal	3.89	10
Mental or Psychiatric Hospital	3.78	9
Welfare Agency	3.75	7
Mental Health or Guidance Clinic	3.73	14
School Counselor	3.65	18
Police	3.62	2
Family or Friends	3.62	2
Probation Officer	3.59	17
Marriage Counselor	3.57	17
Judge	3.57	21
Psychologist	3.55	23
Hospital	3.54	7
Employer or Supervisor	3.50	10
Psychiatrist	3.49	8
Personnel Director	3.42	28
Co-worker	3.15	16
Druggist	3.14	11
Lawyer	2.73	3
Service Occupations (barber, etc.)	2.47	11
Fortune Teller	2.02	11

* Very helpful = 4
Somewhat helpful = 3
Not helpful = 2
Median rating = 3.57

TABLE 6

*Frequency of Mention and Rated Helpfulness for Selected
Community Resources*

	<i>Rated as More Helpful</i>	<i>Rated as Less Helpful</i>
More Frequently Mentioned	Physicians Clergymen Welfare Agencies Mental Hospitals	Psychiatrists Hospitals Family Counselors
Less Frequently Mentioned	Social Workers Teachers Principals School Counselors	Lawyers Service Occupations Fortune Teller

TABLE 7

*Suggestions for Improved Community
Services*

<i>Response Category</i>	<i>Frequency</i>
1. Nothing needed, services adequate	9
2. Better publicity, information about services available	9
3. Community improvements — streets, transportation, schools, government	6
4. Improve juvenile services and homes	5
5. More and better trained mental health professionals	5
6. Services should be improved, but no specific suggestions	4
7. Too much red tape, services too slow	4
8. Medical hospital service needs improving	4
9. Deal more effectively with social problems—crime, delinquency, immorality, etc.	4
10. Mental Health clinics, hospitals	3
11. Better care for retired persons	2
12. Services less centralized, too much control	2
13. Not in favor of agencies, people should help themselves	1
14. Don't give help to people who don't deserve it	1
15. More coordination among agencies	1
16. Miscellaneous	6
17. No response, don't know, no opinion	40

trend to the effect that low social visibility is related to lower perceived helpfulness.

Respondents were asked in an open-end question whether they had suggestions regarding how the community might improve its services to people with problems. Responses are shown in Table 7.

If the number of non-responders (Category 17) is added to responses in Categories 1 and 2 it can be observed that half the subjects made no suggestion for substantive improvement of community services. Of the remaining suggestions, about half were of a relatively specific nature and the rest general ("too much red tape", "services should be improved", etc.).

These data seem to reflect the orientation toward problem conceptualization and solution evident in earlier portions of this paper. Many persons do not view difficulties in living as requiring or amenable to solution by professional services and do not identify specific community needs.

Summary and Conclusions

Data in the published literature and interviews with community resource persons led the authors of this study to explore the naturalistic problem-solving process and the

part played in it by both professionals and non-professionals.

The data allow a tentative description of the process. Many citizens express their own significant personal problems and those of their friends in terms of external, non-psychological concerns. There is reason to suspect, however, that in some cases these expressions represent mental health problems which are manifested in non-mental terms. The importance of terms like "mental health" and "psychiatry" in influencing the way problems are viewed was illustrated when half the interviewees acknowledged knowing someone with a mental health problem, yet only about 10% mentioned emotional problems when asked to describe the major problems of their relatives and friends.

Involvement in the field of mental health may be dysfunctional to the help-seeker if his attempts to increase his interpersonal effectiveness and acceptance result in his being categorized as deviant by peers. Data consonant with this are reported by Phillips,³ who found that individuals are increasingly rejected as they move along a continuum from utilizing no help, to clergy, to psychiatrist to mental hospital.

Other problems inherent in a tendency toward long illness category labels on problem behavior have been discussed elsewhere.⁴ These include the increasing drain on treatment facilities and the possibility of the individual further complicating his own problems by identifying himself in the sick role.

When citizens were asked about inadequacies and suggestions for improvements in existing community facilities for assisting people, their responses fell into the categories of a) needed personnel and facilities, b) improved agency management and coordination, and c) adequate communication between helping resources and the com-

munity. Many were not able to respond with concrete suggestions.

The matter of how problems are defined is important because of its implications for what, if any, helping resources are sought. A compilation of all sources of assistance mentioned by subjects while discussing their problems shows a wide distribution of occupational groupings. Frequently mentioned resources include professional medical and mental health personnel and agencies, but also clergymen, charitable, welfare and service agencies, educators, unions, family, friends and others. An analysis of perceived helpfulness of various resource persons provided further evidence that help-seeking as a decision process involves many interrelated considerations, including problem definition and familiarity with potential resources. Findings document the complexity of the decision process involving selection of helping resources and the important roles played by non-professional individuals in several stages of the help-seeking, referral, and help giving processes.

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Fortune V. Mannino, Ph.D.
Herbert L. Rooney, M.S.S.W.
Ferdinand R. Hassler, M.D.

Distance and the use of the mental health clinic by community professionals

Studies on distance as an important factor in the use of services have focused on distance as it relates to persons who come to a treatment resource. This study examines the location of persons who refer or otherwise influence individuals to go to a treatment facility. Using records of the Mental Health Study Center for a ten-year period, the authors found a significant difference in the number of referrals made by professionals located close to the center as compared to those made by professionals farther away. In addition, differences existed in the percentage of referrals made by agency-connected professionals as opposed to "independent functioning professionals". The authors conclude that more efforts must be made to educate professionals and develop working relationships with them that would lead to more effective use of a treatment resource, since there is evidence to indicate that patients referred from further distances do use the services of the mental health agency.

Many complex problems are involved in the planning of community mental health services, not the least of which concerns the delineation of the geographic area which can be serviced adequately from a particular

base. Federal regulations developed to implement community mental health center legislation contain very specific requirements regarding the size of the population to be served by a center, but leave it to

Dr. Mannino is a research social worker and project director, Mental Health Study Center, National Institute of Mental Health, 2340 University Boulevard E., Adelphi, Md. 20783. Mr. Rooney is Chief, Citizen Participation Branch, NIMH. Dr. Hassler is Chief, Mental Health Career Development Program, NIMH.

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local planners to determine how best to define the geographic areas involved.

Review of Literature

Although the literature offers no hard and fast guidelines as to the optimum geographic area that can be served by a mental health facility, it does contain some information which is relevant to the importance of distance as a determining factor in the use of psychiatric and other specialized health care services. Altman, who studied distances traveled for physician care in western Pennsylvania during 1950-51, found that despite good roads, there were sharp differences between urban and rural dwellers' use of medical specialists, with the former using these services much more frequently than the latter.¹ A marked negative association between frequency with which care from a specialist was sought and the distance traveled suggested that distance presented a serious problem in the use of specialists' services.

In a study concerned with geographic variations in first admission rates to Warren State Hospital, Pennsylvania, for 1948-1952, Person discovered a decreasing rate pattern as distance from the hospital increased for several categories of patients.² One possible explanation offered, of particular interest here, was the likelihood that physicians practicing in the vicinity of the hospital would make more referrals than physicians practicing further away. Hodges and Dorken studied the distance traveled by patients receiving services in three outpatient clinics in Minnesota between 1957 and 1959, and concluded that the distance patients must travel to obtain service appears to be a significant factor in the use of outpatient psychiatric care.³ For rural areas, the practical limit seemed to be 40 to 60 miles, the rough equivalent of one hour's drive by automobile. However, for the

clinic located in Duluth, the only urban center in the study, these authors found that more than 80% of the patients traveled less than one mile to the clinic, which strongly suggests that its clientele resided in the immediate vicinity. Finally, in an analysis of eleven community mental health centers, Glasscote et al., reported that although two of the centers—Massachusetts Mental Health Center and the Nebraska Psychiatric Institute in Omaha—accepted patients from the entire state, the majority of their patients came from nearby.⁴

All of these studies point to distance as an important factor in the use of services, both in urban and in rural areas, and for outpatient care as well as inpatient care. However, each of the studies has focused on distance as it relates to persons who come to a treatment resource, e.g., clinic, hospital, medical specialist. No studies have been done on the persons who refer or otherwise intervene to influence individuals and families to go to a treatment resource. Commonly referred to as community "caretakers" or "caregivers", these persons act as mediating agents between the community and the mental health agency and play a significant part not only in mental health maintenance but also in determining who goes to mental health resources for diagnosis and treatment.

Introduction and Methodology

The purpose of the present report is to add to the work of previous investigators by focusing upon distance in terms of contacts made by community professionals, i.e., "caretakers". Two questions are asked: 1) Is distance associated with the use of a mental health clinic as a contact source for referrals, consultation, and information by community professionals? 2) Does distance reflect differences among community professionals in their use of a mental health clinic

as a contact source (for referral, consultation, and information)?

Data for this report were gathered from the clinical records of the Mental Health Study Center, a research and demonstration field unit of the National Institute of Mental Health. The study period covered was from January, 1952 through December, 1961, during which time the Study Center operated an all-purpose, outpatient psychiatric clinic on a part-time basis. During this period the Center utilized a professional referral intake policy, unique in its attempt to combine clinical services to patients with consultative services to community professionals through requiring some form of contact from a community professional, i.e., nurse, clergyman, physician, policeman, teacher, etc., before a problem was considered for mental health services. Such a contact might result in referral, consultation, or information about community resources, as determined by a discussion of the specific problem between a Mental Health Study Center staff member and the community professional involved.⁶

The records of all such contacts for the ten-year period of study were examined; the addresses of the community professionals' clients about whom the contacts were made were recorded and distances computed. For purposes of this investigation, distance was defined as linear distance, i.e., straight line distance measured on a map by means of a series of concentric circles drawn with the Study Center at the center. Hence, in this report distance refers to the linear distance of community professionals' clients from the Mental Health Study Center.

The setting of the study is Prince George's County, Maryland. Adjacent to Washington, D. C., it had a population of 194,182 in 1950 and 357,395 in 1960, reflecting a growth rate of 84%. Based on information

from the 1960 census, the population is young (median age approximately 25 years, with only 4% over 65), well-educated (median years of school for those over 25 was 12.1), and relatively affluent (median family income was \$7,471). Ninety-one percent of the population is white. Prior to 1900 the county was primarily rural; however, since 1940 it has become increasingly suburban in character, with only about 17% of the population residing in rural areas in 1960. The major occupational groups are clerical, professionals, and craftsmen. In terms of size, the county has a geographical area of about 486 square miles, with a maximum width from east to west of 21 miles, and from north to south of 43 miles. Since there is no direct public transportation running north and south, travel by automobile within the county is the main mode of transportation.

Findings

The data in Table I appear to indicate that distance is a definite factor in the use of the Study Center as a contact source by community professionals. More than half of the contacts made by community professionals concerned clients who lived within four miles of the Center, and more than three-fourths concerned clients who lived within ten miles of the Center.

The data also show substantial differences among the community professionals which reveal certain definite patterns.

First, a reasonably clear distinction appears between those professionals who might be termed "agency associated", i.e., schools, courts, social and welfare agencies, mental health, public health, and medical agencies, and those professionals who are more autonomous and independent in their professional functioning, i.e., physicians, psychiatrists, clergymen, and "others" (this category includes attorneys, social workers

TABLE I

Distance from the Mental Health Study Center of Community Professionals' Clients (January, 1952–December, 1961)

Community Professionals	Mileage							
	Within 4 miles		5–10 miles		11–29 miles		Total	
	N	%	N	%	N	%	N	%
Physicians	446	70.8	134	21.2	50	8.0	630	100.0
Psychiatrists	55	65.4	19	22.7	10	11.9	84	100.0
Schools	252	44.8	187	33.2	122	22.0	561	100.0
Courts and Law Enforcement	50	50.0	41	41.0	9	9.0	100	100.0
Social and Welfare Agencies	101	45.2	66	29.5	56	25.3	223	100.0
Clergy	79	68.0	21	17.9	16	14.1	116	100.0
Mental Health Facility	56	51.9	36	33.4	16	14.7	108	100.0
Medical Facility	81	50.3	54	33.5	26	16.2	161	100.0
Public Health Department	48	44.4	43	39.9	17	15.7	108	100.0
Others	59	70.2	19	22.7	6	7.1	84	100.0
	1227	56.4	620	28.5	328	15.1	2175	100.0

and psychologists in private practice, and personnel from nearby universities and colleges). The large majority of the clients of the latter group, i.e., "independent functioning professionals", are concentrated in the area within four miles of the Center; the percentage of contacts ranges from 65.4% to 70.8%. Less than one-third resided in the more distant areas.

In contrast, there is a more even distribution of clients in both the 0–4 and 5–10 mileage areas for the agency-associated professionals. Within a distance of four miles from the Center, the percentage of contacts ranges from 44.4% to 51.9%; within the 5–10 mile area the contacts range from 29.5% to 39.9%. Hence, rather than the very large concentration of clients within 0–4 miles as was present in the group of more autonomous professionals, we see a more even distribution of clients, at least within the 0–4 and 5–10 mileage areas. The chi square test revealed that this difference was highly significant ($p < .001$) and indicates that distance has a differential effect on those two groups of professionals and their use of the Center as a contact source. A physician, for example, would be less

likely to contact the Center about an individual who lived more than four miles from the Center than would be one of the agency-associated professionals.

However, Table I also shows an important difference that exists within the agency-associated professionals. Two of these groups—the schools and social and welfare agencies—reveal a pattern in their contacts which differs from that of all the other agency-associated professionals. There is a more even spread of the contacts from these two groups which extends to the farthest distance area (11–29 miles). From 44.8% to 45.2% of their contacts represented clients who lived within four miles of the Center; 29.5% to 33.2% represented clients who lived 5–10 miles from the Center; and 22.0% to 25.3% represented clients who lived 11–29 miles from the Center. In contrast, contacts from the other agency-associated professionals were concentrated more heavily in the 0–4 and 5–10 mileage areas, with roughly 15% in the distance farthest from the Center. This difference was also statistically significant ($p < .02$), indicating a differential effect even among the agency-associated professionals.

Discussion

These findings, as in other studies, point to distance as an important factor in the utilization of a mental health agency. However, the present study focuses on community professionals and their contacts rather than on patient use directly. This difference in focus may be particularly significant since many patients make use of mental health services as a result of information presented them by community professionals and agencies. Hence, it seems logical to question whether the findings of previous studies, which show a relationship between distance and patient utilization of mental health services, are in part related to the referral process which precedes the admission of the potential patient to the mental health facility. If the community referral system acts to limit referrals primarily to individuals who live in proximity to the mental health facility, then those individuals who live further away are to some extent blocked from the services of the agency. It is conceivable that greater numbers of patients would be willing to travel further distances to obtain mental health services if they were referred by community professionals.

Although it is not within the scope of the present study to test this idea, we did collect some data which bears upon it. The 50 physician contacts which concerned individuals who resided over ten miles from the Center (see Table I) were re-investigated. (Physician contacts were purposely selected because of the availability of comparative data from another study done at the Mental

Health Study Center.)⁶ Of these 50 contacts, 23 resulted in referrals of individuals who were accepted by the Center for clinical services. Eighteen of these 23 applied for and received services. When these cases are compared with data from a previous study based on all patients referred by physicians over a five-year period who lived within nine miles of the Center (75% actually lived within five miles), we find that the patients who resided over ten miles from the Center fared better, i.e., made longer term use of services than did the patients who lived nearer to the Center:

Though far from conclusive, these data suggest that patients referred from further distances do use the services of the mental health agency.

If we assume that this finding does have some basis in fact, then there are certain implications for program planning which become apparent. Given a mental health center that is concerned about its responsibility to the entire population in its service area, how much of the population it actually deals with may depend upon relationships developed with community professionals. The marked differences among the community professionals found in the present study would appear to indicate that contacts from certain groups tend to be more circumscribed than contacts from others. Using physicians as an example, we find that this group is inclined to use the Center when their clients reside quite nearby. This suggests that the mental health center whose major source of referrals comes from physi-

Number of Interviews Received	Patients who lived over 10 miles from the Center N-18	Patients who lived within 9 miles of the Center N-147
Percents	Percents	Percents
1-9	61	86
10-19	22	4
20-30	16	10

cians may be dealing with a very limited segment of the population. Hence, there may be a need to develop ways of establishing effective relationships with all physicians practicing in the area served by the mental health agency, perhaps through the use of mental health education and consultation. In this manner, the mental health agency would have an opportunity to explore referral practices with physicians with the goal of widening the geographical base of contacts from this professional group.

Similar working relationships would also need to be developed with the clergy and the other "independent functioning professionals". On the other hand, contacts from agency-associated professionals are less circumscribed, probably because many of them represent agencies that are county-wide in function and serve the entire population. Work with these professionals should result in the mental health agency having a more widespread effect on the population.

Finally, the significant difference found within the group of agency-associated professionals is important, since it lends support to our belief that active work with agencies broadens their perception and use of the mental health program. It is our impression that the more even distribution of

contacts from the schools and social and welfare agencies is at least in part the result of rather extensive involvement with these agencies over a number of years through mental health consultation and education.

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Robert E. Kuttner, Ph.D.

Albert B. Lorincz, M.D.

Promiscuity and Prostitution in Urbanized Indian Communities

Prostitution remains an enduring Indian problem despite and perhaps because of acculturation into the ghettos of industrialized urban centers. The stages between promiscuity and prostitution are delineated, and the activities and attitudes of the women described. Some observations on venereal disease, fertility, and methods of police regulation are recorded. Indian prostitution was not found to be a thriving commercial venture but an activity geared to provide a bare sustenance level of support. The close association with alcoholism is emphasized. Opportunities for rehabilitation are estimated to be favorable due to lack of community ostracism. Alcoholism and poverty are indicated to be accompanying factors that must be confronted. The immediate need is social action on the individual, family, and community level to reduce recruitment of new prostitutes.

Prostitution is recognized as a major social problem in addition to being defined as a criminal activity. Separate from social considerations, prostitution also represents a disappointing waste of human potential which makes the entire subject highly per-

tinent for public and private agencies operating in the area of mental health.

As a contribution to this subject, we wish to report on observations compiled on a number of women who were for considerable periods of time living as prostitutes. That these women were American Indians adds a special dimension to this report since it may relate to the process of acculturation and assimilation of a distinct ethnic minority group into the ghettos of large urban communities. This study may also offer insights on various psychological, social, economic, and racial factors that

Dr. Kuttner is a research associate and assistant professor, Department of Obstetrics and Gynecology, University of Chicago, 5841 S. Maryland Ave., Chicago, Ill. 60637. Dr. Lorincz is a professor in the Department of Obstetrics and Gynecology at the Chicago Lying-in Hospital.

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play a role in the decision to enter a life of prostitution.

Methods and Subjects

Data Collection

Some comments on the Indian community involved have previously been made which indicate the relationship of the field worker to the population sampled and also emphasize the informality of the data-gathering process.¹ Most information was obtained directly from the actual participants in several skid row taverns or in Indian homes during drinking parties. Second-hand accounts or "rumors" of the activities of a third party were also collected in these locales. Since study was not originally intended on this matter, no interview technique or questionnaire was prepared. Only after a steady and insistent stream of information had developed between the population and the investigator was the idea of a report considered as a by-product of a research project devoted to other ends.

It was assumed that direct questioning would be resented and hence was avoided. Though one or two pointed questions could be asked about the activities of these women as a part of a conversation, especially if the questions clarified something already volunteered, probing remarks were not well received. These would sometimes be answered by a counter-question: "Are you going to write a book about my life?" The satisfactory reply to this was: "Only when you become a famous call girl."

An attitude of disinterest generated the most data. If invited to comment about some aspect of behavior, the best answer was: "What do you think yourself?" A disclaimer was also used: "That is your business." Conversations about prostitution or promiscuity made up only a small part of the time spent in discussions. It was advan-

tageous to change the subject on occasion, stating that the investigator was only interested in alcoholism or some other medical or social problem, which was a truthful statement for much of the period of contact.

Information that was volunteered was sometimes offered as an antidote to or refutation of rumors that an individual felt were being circulated by others about her activities. If the rumors were not denied, then justification was attempted for whatever petty scandal was currently featured in tavern gossip. This was particularly true for individuals who were known for long intervals and who desired to preserve some elements of respectability or propriety in the eyes of the investigator.

Reliability of Data

Prostitutes are commonly regarded to be habitual liars. Their ability to display synthetic affection toward persons they may actually dislike and their facility in inventing stories for the police or alibis for the courts are indications of this trait. The accuracy of the information gathered in this study thus becomes an important methodological question.

The subjects were surprisingly frank in supplying data. Many of the conversations included several additional listeners who were long acquainted with both the investigator and the women and could be depended on to correct any inaccuracies. Biographical details were the common property of all members of the community and little distortion of fact was possible even if attempted.

Primary data was observational and could not be manipulated. Secondary data would be interpreted by critics as gossip, but almost all conversations in these communities consisted of gossip interlarded with older background data on family or per-

sonal history which were readily verifiable. These women were not very imaginative. When cliques formed, as they did frequently, rival factions would vilify each other to any available audience but rarely generated any new derogatory material. The worse things that could be said about an absent person were already known by everyone and hence verified in advance.

Misinformation sometimes turned up in minor matters. Efforts to gain sympathy were the motivations for misleading information. It would be implied that a girl was sent to a correctional institute because her mother did not want to raise her. The parents would deny this and offer evidence that the girl's truancy, drinking, or promiscuity resulted in her detention by juvenile authorities.

Standards of behavior were quickly formulated toward the investigator. The emphasis was on honesty, good manners, and non-involvement in quarrels. Indian contacts exhibited protective concern for the investigator and criticized lapses in conduct by others. The impression, after almost five years of contact, was that the investigator was the recipient of wide acceptance and trust which make these data as useful as any gathered by more formally structured surveys.

The Indian Population

About one hundred women of all ages entered into these observations at some point. Firsthand, detailed information developed over several years applied to only about fifty of these women. By the definitions to be elaborated in the text, only about thirty of these women followed for any period of time a pattern of living that can be considered to be prostitution. The main subjects were all urbanized South Dakota Sioux, Winnebago and Omahas belonging to the Sioux linguistic stock. One

Apache, one Chippewa, and some Mexican women were also encountered in the Nebraska area. Several white women were met through Indian contacts. No data were collected since this was not a comparative study. In the Chicago area, all the white women were Appalachian migrants. In Nebraska, one of the white women was distinctly of upper middle class origin. All Indian women were born in the urban area or were city residents from earliest childhood.

Geographic Area

The major portion of the study was carried out in the skid row of Omaha, Nebraska. Lincoln, Nebraska provided only anecdotal information. Confirmatory material was obtained from Sioux City, Iowa, the nearest metropolitan area to the Omaha and Winnebago reservations. The Uptown district of Chicago furnished additional data but actual survey time was not extensive. This district is a badly deteriorated, economically deprived area, heavily settled by Appalachian migrants, and containing urban colonies of Indians and Negroes. Several Indian women distributed their time equally between Sioux City, Omaha, and Chicago. Many Indians in the Uptown district belonged to Iowa, Illinois or Wisconsin tribes and no opportunity developed to include them in this study. Winnebago Indians originating from non-Nebraska reservations were also excluded.

Surprising geographic mobility was found. Three of the women had worked as prostitutes in Omaha, Sioux City and Chicago. Two others were active in the first two of these cities, and had also lived in the third, but data on their activities in the last area were not ascertainable. Many Sioux women were stated to have been prostitutes in South Dakota cities but the in-

formation was anecdotal. One Omaha woman mentioned prior activity in Oklahoma. A Chippewa woman admitted prostitution in Minnesota. Previous background on a claimed Apache woman was unobtainable. Women from Lincoln sometimes visited Omaha and elsewhere, but these movements were not documented.

Scope of Indian Prostitution

It has been asserted by recognized experts of Indian history that until World War II the only readily available employment for Indians off reservations was prostitution for young women.² Today, the Bureau of Indian Affairs is the major employer of Indians. Indians with skills or initiative find many opportunities for economic advancement off the reservations. But women lacking education or job skills are frequently channelled into prostitution and, for the Indian community, the problem is as grave as it was a generation ago.

Government statistics on this matter are meaningless. For one of the study years (1965), the Department of Justice in its *Uniform Crime Reports*, listed 142 arrests for Indian prostitution.³ A single prostitute in this study, working from one Indian skid row bar, makes this many contacts in three or four months. Looked at another way, the known Indian prostitutes in a single urban district in one city in this survey, can accumulate this many violations during one long weekend. Since there are few arrests, and those mostly for drunkenness or vagrancy, such statistics are of little help in gauging the extent of the problem.

Informants stated that Indian prostitutes were active throughout the country. The observations in this study were confined to a limited territory, but any fair projection of firsthand data to unvisited locales would indicate that Indians are still heavily over-

represented in this exploitative and criminal occupation.

The role of poverty, as separate from the stresses of urbanization, cannot be estimated, but socio-economic changes over two generations have not benefited the Indian community to the degree that would have made prostitution an unnecessary economic resource. One mother and daughter team was encountered in this study, and several other women were known to have mothers who once worked as prostitutes. Such chains of continuity make it implausible that pressures that make prostitutes have been markedly relieved since World War II. No mother or female guardian, no matter how afflicted with chronic alcoholism, desired her daughter to follow in her footsteps.

Feeble-mindedness must be eliminated as a cause. Chronic alcoholism made it hard to assess social capacities in some of these women. Many were ignorant and uneducated, but all were literate. One girl read psychology texts in prison. Most were capable of serious discussions when sober but had little incentive to do so. None read newspapers. A few read confession type magazines. They were well informed on cosmetics, clothing, fashions, hair preparations and new dances and songs. Other interests, such as sports or card games, reflected their contemporary Indian background.

Definitions of Promiscuity and Prostitution

Promiscuity at an early age and the birth of illegitimate children are not strongly stigmatized in the Indian communities involved in this survey. The reason for this is not patent and discussion of the matter not presently relevant. Some of the causes may be traced to tribal disorganization with the accompanying breakdown of regulatory

mores. More likely, the problems of urbanization which require adjustment to the bottom socio-cultural niche of ghetto neighborhoods play an important part. In this sense, the Indian reaction would not be expected to differ greatly from those of other economically handicapped minorities in large cities.

The existence of promiscuity makes it necessary to classify social behavior into finer divisions. Where rigid puritanical mores persist, distinctions are more immediately apparent. For a skid row population, various gradations can be set up which not only serve the purposes of classification but also represent evolutionary stages which mark the progression of the subjects from promiscuity to overt prostitution.

1. *Normal promiscuity*: The standard for most of this population, this applies mainly to younger girls before the first, long-term relationship develops. Several short-term "affairs" are common, as are the resulting illegitimate children. A long-term relationship may sometimes occur first in the middle teens, lasting for months or more than a year; but even these legal or extra-legal marriages may be preceded by promiscuous episodes. The parents may not approve of this conduct, but may not be able to control it.
2. *Extreme promiscuity*: Very little discretion or advanced planning goes into relationships with men. No pretence of a stable arrangement is maintained in most cases. Even if one man emerges as a fairly steady companion, both partners are often disloyal and new partners are sought on the most trivial grounds. Heavy drinking is diagnostic of this stage.
3. *Compensated promiscuity*: These

women go to taverns to drink but an exploitative aspect has entered into their relationships with men. They expect rewards for their favors. These women usually have one or more children and have been through at least one long-term legal or extra-legal marriage. Two sub-grades can be discerned:

- a. *Sequential relationships*: A substitute or temporary husband is acquired who makes a contribution to the family of the woman. This is in addition to buying alcohol. Women in this grade have usually kept their children from earlier marriages or affairs, and also maintain homes in municipal projects or live with relatives or parents. The man may buy groceries, clothes and shoes for the woman and her children, and even take them for car rides or to motion pictures. A maximum contribution such as a winter coat or a television set is unusual. The man may spend nights or even days in the woman's home or room and is acquainted with and accepted by her family, but he generally has his own quarters. Reasonable loyalty is maintained between couples and new partners are not sought until the union is dissolved. If the man goes to jail for a short sentence, the woman becomes promiscuous again until his release.
- b. *Simultaneous relationships*: This is almost an exploratory phase during which a woman goes with several men until she either settles on a temporary husband or moves on to prostitution. These women usually have not kept their children or they have been placed with relatives or the in-law family. Compensation may be no more than alcohol and an occasional gift (clothing or trinkets). When the purchase of alcohol becomes the primary economic motive, money is requested in exchange for favors. While male companions invariably pay for the drinks, the woman must have cash to start herself off in a tavern the following morning until she meets one of her "live ones". Rather than homes, women at this grade are already spending many of their nights in skid row hotels.

4. *Professional promiscuity*: These women are already prostitutes. Their primary purpose is no longer to go to bars for companionship and drinks, but to find customers so that they can obtain money for alcohol. No degree of acquaintanceship is necessary for a relationship. Total strangers who offer drinks are rapidly solicited even if the intention of the man was not to make a "pick up".

Prostitutes, once started, continue for many months or many years. Reverse movement, to stage 3a, does sometimes occur, but when such relationships terminate, there is no pause in commencing prostitution. Even if a long-term relationship is started, "cheating" is very common. Any shortage of cash sends the woman back to prostitution. Little or no sacrifice is made to remain faithful to one man. Since the available male partners in a skid row environment are not able to offer many economic comforts, prostitution is always an attractive method for obtaining whatever is immediately desired, and little concern is shown over the danger of dissolving the relationship.

Further classification of prostitutes contributes nothing. The women themselves recognize a hierarchy—those who do not go with Negroes and those who do. An outside observer may set up a third category—those who deny they go with Negroes but do so surreptitiously.

Recruitment

Women from a promiscuous and impoverished environment need little persuasion to enter prostitution. There is a gradual drifting with age through the previously detailed stages of promiscuity. Random factors and forces operate to keep a woman from reaching the final phase of a strong

and intact family, a successful marriage, or some unmeasured internal restraint which operates unseen by the observer. Two women with similar socio-economic backgrounds may be lifelong companions, drinking in the same tavern, and yet one will be an active prostitute and the other completely resistant to the idea.

One case of recruitment by a female relative was noted. An older cousin, accorded by Indian kinship the rank of "aunt", induced an already promiscuous girl of approximately 16 years to accompany her to a Negro home that served as a gambling and bootleg liquor establishment. Another girl of that age received financial rewards from a Negro neighbor when the mother was returned to a hospital for a chronic lung ailment. Support for an older brother, a school dropout, was also acquired. An Indian girl habitually arrested for vagrancy became dependent on an older Negro male who paid her bond and fines. Another woman who lived with a Negro family containing unemployed males, was encouraged to frequent skid row bars in Sioux City and "come home with some bread".

The part played by Negroes in recruitment and procuring was understandably large. Economically marginal Negro districts adjoined or overlapped the Indian skid row communities. As earlier urban migrants, the Negroes dominated ghetto vice to the degree that it was organized. The scope of commercialized vice in the much larger Negro areas could not be estimated by observations made within the Indian community. Negro informants did not distinguish between true commercialization and merely exploited promiscuity. The nature of the Indian women suggested that they were unlikely to long participate in an enterprise which reduced their profits, forced them to be absent for many hours from the social life of the Indian bars, and

rewarded a male procurer who gambled away the money earned by the women.

Only one case of true commercialization was discovered. A Negro felon who received a small pension for a disability actively procured for Indian women. Though several Indian prostitutes worked for him sequentially, at no time did he have more than two women in his "stable". A white woman and a Negro woman were also at times available to him. Upon his return to prison for another crime, a Negro associate inherited his Indians.

One Indian woman was permitted to "hustle" when her Negro common-law husband needed money for alcohol. She claimed he was good thief and this was an infrequent need. Nevertheless, she solicited in bars on a daily basis. When he was in prison, she supported herself by continuing her activities. Negro bootleg establishments frequently were headquarters for vice activity or pick-ups. This was true for all cities. If a resident Indian female was not present, one could readily be obtained by telephoning a skid row bar.

Indian prostitutes locating in a new city would move in with Negro acquaintances if they were unable to find lodging with relatives or friends. The women would support themselves by their activities and also contribute to the rent and other expenses. Since many Negroes were unemployed and also alcoholic, this pooling of resources was mutually satisfactory. This arrangement tended to collapse if the Negro male pursued other women or if the Indian girl spent too much time in Indian bars with her friends.

Many Negroes were employed in meat-packing plants and in construction work and could support a common-law wife. Several Mexican and Indian women entered long-term relationships with steadily employed Negroes and resided in rented homes

in better Negro neighborhoods. These women were regarded as married and had the same status as couples who had been raising families for many years in the Negro area. Except for exchanging visits with their immediate families, these women were separated from the Indian community and not a part of its social life.

Whites played a role in alcoholic seduction, though a number of marriages ensued if pregnancy resulted. Many whites in the skid row environment were already petty criminals and products of correctional institutions. Such marriages as occurred were not marked by longevity, though the Indian wives were not otherwise driven to prostitution. Whites were the main customers for the favors of Indian women, as described below.

Life Pattern of the Prostitute

The daily activities of these Indian prostitutes are so similar that the broadest description is applicable to all. Alcoholism brings these women out early in the day unless they have cached a supply of liquor in their rooms. On weekdays they would be in taverns almost from opening time, which varied from city to city. The money earned the previous day, a "starter", was their entry fee to the bars. Conversation with derelicts, winos, Indians, bartenders and other "regulars" occupied time until customers appeared. The customers knew where to go for pick-ups. In Omaha, cattle raisers attending livestock auctions gravitated to skid row Indian bars. In Sioux City, farmers coming to markets or unskilled laborers between jobs were the principal customers. In both cities, pensioned middle-aged men and partly or seasonally employed younger men made up the clientele. In Chicago, factory shift-workers provided the morning or afternoon trade.

By late morning, most girls had made one score and had adequate funds for the rest of the day. The evening hours were spent in social activities, visiting friends and drinking. After bars were closed, all-night bootleg places were sought to continue the drinking, which was usually alcohol in coffee cups. The bootleg taverns were in Negro areas. Before bars were closed, a second customer might be sought if funds were low. This rarely happened as these girls depended on male companions or Indian friends for most bar drinks. If taxi fare, a ride home, or an emergency bottle was needed, male companions or customers were solicited. Favors were also granted for sharing a bed if there was no inclination to return to the Indian neighborhood.

These women were not intent on getting rich and were satisfied with one "mark" who paid sufficiently well to cover the day's drinking expenses. Convenient skid-row hotels were the scene of business transactions. Police activity included these hotels in searches for Indians suspected of crimes and for bond-jumpers, but no control over vice was evident. Only urban renewal threatened these establishments, some of which disappeared while this study was progressing. Negroes patronizing these women had to transport them by car or taxi to hotels in other neighborhoods, or to Negro "bootleg" apartments which had beds for this purpose.

Weekends imposed a different schedule of activities and provided a more varied clientele. Customers were sought in the evening since working class men were at home with their families or pursuing other recreational interests. Bar customers were now recently paid individuals out for social drinking and other gregarious pastimes. The women went with the men who paid for their drinks during the evening. Most of the fights in these Indian bars which

were not between Indians were caused by men picking up women who had been with other companions most of the night. Expenditures for drinks over the counter, for food and snacks, for the music box, represented a sizeable investment and latecomers who tried to lure the women away with a bottle at closing time were strongly resented. Women sometimes encouraged "live ones" to spend money while actually waiting for someone better appearing or more affluent to come along.

These prostitutes devoted more time to regular customers on weekends. Old boy-friends, husbands, lovers and long-term companions who worked or did not drink on weekdays consumed a good portion of this time. All-night drinking parties in homes often ensued. Completely new faces were rare on weekends and such prostitution as occurred was not totally devoid of warmer social qualities. In other words, money was not the sole basis of these weekend reunions.

The presence of family and relatives on weekends may also have inhibited blatant commercialism. Many of the women drank with sibs, life-long friends, and parents or other close kin. Parties would continue the social activities after tavern closing hours. The pressing need for a drink in the morning was temporarily solved by staying with friends or relatives who would make available their stocks or seek new supplies on awakening.

Personal and Family Attitudes

There was little opportunity for serious probing of the attitudes of these women toward their activities. Questioning on this subject carried with it the implication that

a moral doubt on the part of the investigator had to be resolved. Much indirect information was contributed on this subject by reference to other prostitutes whose behavior may have been a topic of conversation. The self-esteem of these women appeared to be principally maintained by a series of rationalizations designed to show their superiority over their economic or social rivals. This was always on a comparative basis with reference to a specific third party who was usually also well known to the investigator.

With regard to other prostitutes, superior morality was demonstrated by such statements as: "At least I don't hide (or deny) it," (This implies that other prostitutes are just as bad but more surreptitious) "At least I don't lie about it," (Implying superior honesty) "At least I don't roll people," (Implying other girls steal from customers) or "At least I send my family (mother) money," (Implying a mitigating circumstance—helping to support younger sibs—which other members of the family denied).

Concerning merely promiscuous girls, the following rationalizations were employed: "At least I don't pretend to be better than anyone else," (In the context that promiscuous girls draw a line at prostitution because they are snobs) and "At least I pay my own way," (In a restaurant, implying that promiscuous girls "sponge off" their families). Other such demonstrations of superior morality with reference to specific comparisons were: "At least I didn't give away my children (for adoption)," "At least I've never been arrested," or "At least I don't drink wine . . . don't use V," (Injecting the contents of an amphetamine-containing nasal inhaler).

Family reaction was ill-defined. In some cases the family was unaware when the line between promiscuity and overt prostitution had been passed. Suspicions may have

been aroused by rumors, but these were insufficient grounds for exerting what small pressure the family may have been able to dispense. Divided and often geographically dispersed families, with alcoholic, criminal, or indifferent members, had little pressure to use except with the very youngest children.

Venereal Disease, Contraception and Fertility

Venereal disease was widespread. Promiscuous females who were not prostitutes were infected by promiscuous boyfriends. Considerable delay often occurred before a visit to a health clinic. Much treatment for males and females was carried out after arrests for drunkenness or vagrancy. Gonorrhea was a topic of some conversations. No one admitted acquiring syphilis. Information on venereal disease was seldom requested, but the investigator routinely urged rapid treatment whenever a case of infection was implied by gossip. Misinformation on the nature of venereal disease was prevalent. One individual stated that untreated gonorrhea turned into syphilis. Cases of untreated gonorrhea of months and years duration were evident among prostitutes who rarely could suggest who infected them.

Most of the women in this study already had several children before becoming prostitutes. Some were obviously infertile for periods of years. Contraception was never used by females and very rarely by customers. There was no direct questioning beyond the statement made at an appropriate time: "What happens if you get pregnant?" The answer was one based on experience—"I can't have children anymore." Because of venereal disease and other factors involved in extreme promiscuity, prostitutes often have low fertility.⁴ One white prostitute claimed she was sterilized after

a number of children because of a rheumatic heart, but Indian companions stated knowledge of her having a miscarriage.

Three of four girls who were extremely promiscuous or were prostitutes before eighteen years of age had no children four years later when observations were concluded. One of the infertile girls had been re-infected with gonorrhea several times in several cities.

An oddity was that two women who had long careers of prostitution were still fertile and giving children up for adoption at regular intervals. Despite almost ten years of prostitution, punctuated by only an occasional extra-legal marriage lasting months or at most a year, these two cases were demonstrably fertile and also demonstrably infected. Since blatant prostitution attracted the attention of the police, these girls were frequently charged with vagrancy and received almost routine health checks. Less identifiable prostitutes were the ones harboring chronic infections.

Rival prostitutes vilified each other by gossip concerning venereal disease. Acne, bruises, scars or other skin blemishes were stated to be evidence of syphilis. This was about the extreme level of invented gossip which the investigator encountered. Other stigmata that were employed in derogation of rivals were red eyes due to alcoholic dissipation and black eyes inflicted by boy-friends in drunken quarrels. Many of these girls wore sunglasses day and night despite the dim lighting in some bars.

Police Regulation

Copies of birth certificates or liquor bureau identification cards had to be carried to prove age in taverns. After the women were recognized as being of legal drinking age, identification was still requested of them, even of obviously older women. Many women without cards were

picked up by police even if 21 years of age. A minor degree of intoxication could lead to arrest and jail sentence.

Identification cards were frequently lost, misplaced, lent to younger girls, or stolen along with a purse when the woman was drunk. Replacement required writing to the state capital and paying a minimal fee. The effort involved too much trouble and an entire sequence of arrests could result. After some episodes of detention, either a new card would be obtained or a woman would temporarily retire into an extra-legal marriage. A visit to relatives in another city or a return to her family still living on a reservation could ensue. Identification cards contributed to police control of the vice and alcoholism problem but appeared to these women as simple harassment.

Vice squad members were soon recognized despite rotation. They travelled in pairs, were better dressed than customers and illegally parked unmarked cars at hydrants or at corner intersections when making checks. Unmarked cars tended to be of the same make, model and color and were also readily recognized.

The tavern would be alerted to the arrival of the police by petty criminals lounging at the windows. The bartender would quiet the customers. Underage visitors with parents were scrupulously evicted before the set curfew hour by bartenders conscious of possible licensing difficulties. Police inspections were more frequent on weekends. Well-dressed patrons were sometimes asked if they knew where they were, the implication being that a sign of affluence might invite robbery attempts. All arrests known to the investigator were for drunkenness, vagrancy or disorderly conduct. It appears possible that most of these women have never been charged with prostitution.

Underage girls were often picked up in the vicinity of bars during late hours. Juvenile authorities were sometimes able to commit these girls to correctional institutions for either drinking or promiscuous behavior. If a family check showed the absence of a responsible guardian, arrangements for custodial care with public or private agencies were attempted. The girls would reappear months or years later with little apparent change in conduct.

Other criminal activity included petty theft from male customers and pilfering from female drinkers who left purses unguarded. Few police complaints were made; the sums involved were small and the embarrassment of being a "mark" was considerable. Almost all women boasted of at least one opportunity in the past which resulted in rolling a customer for as much as one-hundred dollars. More than one claim to such good fortune would not have been believed.

Opportunities for Rehabilitation

It is clear that the Indian women are prostitutes primarily to support a drinking habit. When funds adequate for a day or two of drinking are accumulated, active solicitation can hardly be detected. This is not to say that if a good opportunity presents itself, these women will decline it. Extra money can always be used for clothes or miscellaneous needs. But the immediate and pressing problem is to acquire money to drink that will carry them through to the next morning.

Not all of these women are alcoholics. Periods of sobriety lasting weeks or months occur in the lives of many, perhaps following release from jail or due to illness. Short periods of marriage or of useful economic activity may be tried, but relapses to prostitution seem destined.

Added to the problem of abstaining from alcohol, which can occur after what are referred to as phenomenal hangovers, there is the sacrifice of social life which revolves around the Indian or skid row taverns. This is the meeting ground for friends and relatives and the nerve point of community life. Staying home with husbands or relatives to look at television every day involves the sacrifice of withdrawing from the life of the community. Parties at home keep the women aware of gossip, but eventually a visit to a bar and a few beers starts the pattern of drinking again and total relapse is thereafter imminent.

Regular employment could conceivably support a drinking habit, but the hours spent on the job would require the surrender of daytime hours in the taverns and drastically cut short the night hours. Absenteeism, erratic work habits, and gross inefficiency on the job make it difficult to keep employment for long. The financial rewards of such unskilled labor are not sufficient to encourage much sentiment for reform.

In a theoretical sense, if prostitution were not complicated by alcoholism, remedial action could be taken by providing suitable alternatives. But this would pose new problems. These women are almost all past the age where formal educational or vocational training is practical. There is little academic background to build on and too little motivation to undertake any prolonged course of training or study.

Schooling for these women beyond eight grades rarely continued for more than one or two years unless they were confined to a correctional institution. Not one woman had a high school diploma or the reasonable equivalent, though 12 years of school may have been completed in one case because of the above mentioned confinement. Verbal abilities are uniformly poor, and

spelling and grammar always appalling even by present-day standards. Penmanship for Indians, both male and female, is highly ornate, a legacy from elementary school drill where calligraphy gets more emphasis than communication. Any kind of office or clerical work is at best a very unlikely prospect.

Previous job experience included occasional weekend employment as a barmaid. Before becoming prostitutes, a number of girls performed unskilled labor in the food and poultry industries, in hotel laundries, and in one novelty factory for periods lasting up to six months, but never returned to such work in subsequent years.

It would be a grave error to suppose these women enjoy or prefer their mode of life. Despite a superficially indifferent attitude to the fact that they are prostitutes, these women would hardly pretend that they have achieved their life goals and are satisfied remaining as they are. If the alcoholism problem could be controlled, without social isolation, and other economic opportunities offered, no insurmountable obstacles would bar the task of rehabilitation. Such economic opportunities must involve on-the-job training so that financial compensation accompanies the job activity itself. The level of compensation must provide for an acceptable standard of living to prevent relapses.

All of the women expressed the hope that someday, in some manner, they could raise their children or at least contribute to their support. This maternal reaction can possibly be utilized to strengthen motivation. Many of these women have had children, and though some have been given away to adoption agencies, others may have been retained by grandmothers, relatives, or the father's family. The hope of recovering these children, usually the first or last born, is very real and sincere. A number of women

recognized alcoholism as the chief block to this ambition.

A few prostitutes showed some initiative for employment when living with a temporary husband. The added income was planned for a luxury, such as a car, but no significant accumulation of funds seemed to result. Husbands themselves would drink and gamble on weekends, and the poverty cycle remained unbroken. Surplus cash always went for clothing with both alcoholic and non-alcoholic prostitutes if no children were in the household.

A promising factor was the absence of community rejection of these women. When promiscuity is a norm in a society, acceptance of reformed prostitutes poses no major hurdles. Some stigma may remain, shown mainly by malicious gossip, but this is readily endured. Kinship ties make available enough relatives to defend a woman, and since most families have "black sheep" members there can be no campaign of puritanical ostracism against anyone. Prostitutes converse with female relatives and friends without inhibition, and walking into a hotel with a strange male in full sight of bar patrons is not construed as something requiring secrecy. Few questions are asked and these may be parried by coarse humor. If family pressure can not avert prostitution, a resigned complacency develops which does not interfere with previous cordial relations.

The investigator encountered older women who acquired a semblance of respectability by living with middle-aged pensioned men, widowers, and sporadically employed laborers in relationships that were tantamount to marriage. These men were usually Caucasians and lifetime inhabitants of skid row. Since the early activities of these women were recounted by others, the decision as to whether they were prostitutes at one time depends on anecdotal informa-

tion, but there was no reason to suspect misinformation. The biographical details were repeated by members of the family, who in some cases were still prostitutes.

Rehabilitation steps would require the earlier retirement of prostitutes to such stable relationships. Reverse movement back to a more restrained promiscuity should be encouraged by means other than police raids. Alcoholism is the most serious obstacle. Substitute economic opportunities have to be provided until new attempts at marriage can be made. Arrangements to recover children should be encouraged if the couple manifest a willingness to undertake the burden and can demonstrate that the children would enjoy a materially improved physical environment.

It is, of course, evident that rehabilitation of Indian prostitutes is not an undertaking that can be initiated by a series of observations of the kind presented here. The actual implementation of any remedial action must proceed along a broad front that touches every aspect of skid row life. For the Indian, this implies steps to organize a viable environment to neutralize the ravages of detribalization and urbanization. Recognition of the role of alcoholism is a prerequisite. The entire gamut of problems resulting from the failure of family discipline, the inadequacy of education and the lack of suitable job opportunities must be faced and dealt with.

The main purpose of any community effort must be directed at reducing the supply of new recruits. The difficult task of rehabilitation could thereby be avoided. A policy of prevention calls for early intervention to counteract the debasing influences

found in a poverty-ridden ghetto. Measures to strengthen the family, extend education, and decrease unemployment would eliminate the pressures that channel neglected and disenchanted girls into prostitution. The young Indian male must be included in this program since any social action which improves the educational and economic resources of future husbands and fathers would serve to diminish the family fragmentation which propels many women into prostitution.

Disillusioned social workers may not expect much response to the customary welfare remedies that have been tested in many urban ghettos. Past experience may not be a good guide in dealing with Indians. Statistical evidence can be assembled to show that Indian social capacities dramatically improve with even minor increments in socio-economic status.^{5, 6} Even if this were not the case, sweeping community action would be justified on the moral ground that the nation's most aggrieved minority should not be victimized to the point where it supplies a disproportionate number of its women for the vice of our cities.

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Margaret S. Barbee, M.A.

K. L. Berry, M.A.

Donald G. Miles, Ed.D.

The effect of work therapy on patients' responses to other hospital therapies

The authors hypothesized that participants in work therapy would respond more favorably to other hospital therapies than would non-participants. While results showed a significant difference between the participant and nonparticipant groups in over-all response to therapy, no significant differences were found between the two groups in their response to group, occupational, recreational therapy and social activity.

The function and value of industrial work in a psychiatric setting are of growing interest in mental health. Many European psychiatric facilities have provided industrial work as part of their comprehensive treatment services for many years, and observers of these programs suggest that work

as therapy (W.T.) may constitute a major addition to psychotherapeutic techniques.

Stimulated by the successes of milieu therapy, many institutions for the mentally ill in the United States have recently begun to establish formal programs of paid work for patients as legitimate therapeutic practice, largely independent of traditionally post-hospital vocational rehabilitation services. Viewed in the context of the total

At the time this work was done the authors were members of the Vocational Service Dept. of the Fort Logan Mental Health Center in Colorado. Mrs. Barbee is now with the Dept. of Health and Hospitals, West Sixth Avenue and Cherokee St., Denver, Colo. 80204. Dr. Miles is Chief, Mental Hygiene Program Analyst with the New York State Department of Mental Hygiene and Mr. Berry is Research Co-ordinator for Manpower Studies in Denver.

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therapeutic community, meaningful work is well suited to occupying major periods in the patient's day that otherwise may not be constructively used. It provides continuous physical movement, a realistic incentive to activity (pay), a natural stimulus to group activity, and the goal of eventual vocational rehabilitation.

In addition to productively employing the time that patients would otherwise be unable to structure, the remunerative and socially relevant activities of W.T. maintain a natural link with real-world activities. Some chronic schizophrenic patients are reported to have shown significant changes in the assessment of reality factors and important decreases in abnormal behavior (restlessness, mannerisms, immobility) as a result of participation in work therapy.¹⁻² Moreover, the benefits of work as therapy are seen as potentially extending to the entire diagnostic spectrum.³⁻⁴ Denber⁵ views work therapy as the "focus of daily activities, acting as a matrix for other therapeutic treatments," for both chronic and acute patients. Many other authors agree that work therapy supports and facilitates the entire psychiatric process.⁶⁻⁸ The modification in behavior and attitudes of participants in work therapy, as reported in the literature, indicates that generally positive responses in many areas may be expected during as well as after hospitalization.

The Problem

The purpose of this study was to evaluate the effect of work therapy on patients' responses to the other specific therapies in which they are normally involved during hospitalization. If, as Denber suggests, work therapy is a "matrix for other psychiatric treatments," demonstrable differences in responses to other therapies should be found

between patients provided W.T. and those not so treated.

A controlled research design was established that employed data from a larger NIMH-supported work therapy evaluation project in progress at the Fort Logan Mental Health Center, Denver, Colorado. In conjunction with the project, a workshop was established on the hospital grounds; and contracts and materials were obtained from local industries for jobs such as packaging, light assembly, and the production of simple but useful products. The workshop setting was designed to be as physically similar to an ordinary place of industrial work as possible.

Participants in the program worked approximately seven hours per week, and were paid weekly on a group piecework basis—that is, each individual shared equally in the earnings of his W.T. group regardless of his contribution to its success. Under this system, an individual in a group of typical employees would earn \$1.25 per hour (then the minimum wage) whereas patients in most work therapy groups earned about \$0.40. A paid job within the limits of his abilities was made available to everyone assigned to work therapy, and no patient was ever seen who could not work at all. The patients worked under the direction of workshop supervisors who served the dual function of therapist and foreman, maintaining a realistic, businesslike, but basically supportive atmosphere.

Five specific hypotheses were proposed concerning the effects of participation in work therapy upon response to other treatment modalities: that W.T. participants would respond more favorably than non-participants to (1) group therapy, (2) occupational therapy, (3) recreational therapy, (4) social activity therapy, and (5) the total therapeutic milieu.

Method

Sample

Upon admission to Fort Logan's adult psychiatric division, all patients were randomly assigned to one of two groups—work therapy participant and non-participant. Assignment to the groups was based solely on the order in which the patients entered the admission office. The sample was further refined by requiring that each subject must have remained in intensive treatment for a minimum of 20 days, and that participants must have attended work therapy for at least ten days, whereas non-participants must not have attended any work therapy sessions. Failure to meet these criteria led to removal from the sample.

Data were obtained for a total of 155 subjects: 71 participants and 84 non-participants. Subjects in the two groups were comparable in age, sex, and educational level.

Scale

A psychiatric disposition summary, including a response to treatment section, is routinely completed for each patient when he is initially transferred to "low-intensity" care (evening care, outpatient division, home care, family care) or discharged. The patient's responses to the various therapeutic situations in the hospital are rated on a seven-point scale ranging from 1 (marked benefit) to 7 (much worse) by any member of the clinical staff who has been closely associated with the patient during treatment.

For this study, the ratings for group therapy, occupational therapy, recreational therapy, social activity therapy, and over-all response to the total therapeutic program were considered.

Procedure

The method of testing each specific hypothesis involved a comparison of the mean disposition summary ratings of the participant group with the means of the non-participant group. T-tests were used to determine whether there was a significant difference between the mean ratings of the two groups.

Results

The mean disposition summary ratings for each group, together with the standard

deviation from the mean, are presented in Table 1. To facilitate interpretation, it

TABLE 1
Summary of mean responses to therapies

Therapy	Participant		Non-participant	
	Mean	S.D.	Mean	S.D.
Group	2.48	0.734	2.61	0.792
Occupational	2.59	0.575	2.73	0.766
Recreational	2.54	0.629	2.68	0.799
Social activity	2.39	0.643	2.46	0.828
Over-all response	2.86	0.743	3.29	0.977

should be borne in mind that the lower the mean score, the better was the average response of the group to a particular form of therapy.

The results of testing the first hypothesis, involving response to group therapy, showed that the mean score of the participant group was lower than that of the non-participant group. However, the t-test revealed no statistically significant difference (see Table 2).

TABLE 2
Results of t-tests: participants v. non-participants

Therapy	t	df
Group	1.045	154
Occupational	1.248	153
Recreational	1.042	154
Social activity	0.5910	154
Over-all response	3.085*	153

* Significant at 0.005 level.

Examination of the mean responses to occupational therapy, hypothesis two, also revealed no significant differences between the groups, although in this analysis the

mean of the participant group was again found to be lower than that of the non-participant group.

The results for hypothesis three, involving response to recreational therapy, exactly paralleled those for hypothesis one, both in the ranking of means and in lack of statistical significance, as may be seen in Tables 1 and 2.

The results obtained for response to social activity therapy, the fourth hypothesis, paralleled those for occupational therapy, hypothesis two, that is, the participants rated lower than the non-participants; but, again, the difference was not significant.

Finally, analysis of hypothesis five, over-all response to therapy, revealed that the participants' mean rating was significantly lower than that of the non-participants ($P < 0.005$).

Discussion

The results obtained from testing the fifth hypothesis, over-all response to therapy, together with the consistently lower mean scores of the participant group for the individual types of therapy, seem to provide support for the hypothesis that patients in work therapy will respond more favorably to other hospital therapies than will patients not in work therapy. Because these patients were randomly assigned at admission to the participant group and were similar to members of the non-participant group (who were also randomly assigned) in several demographic variables, there is reasonable assurance that no systematic differences existed between the two groups before the application of the experimental condition, work therapy.

Because the results were significant only for over-all response to therapy and not for any specific therapy, there is some reason

to postulate that work therapy influences the patient's general receptivity to therapy rather than that it provides him with the skills or knowledge necessary for success in other specific therapies.

However, the almost undefined nature of the treatment response scale might also have been a factor in the relatively low order relationship found between work therapy and the specific therapies. It may be that the typical clinician has difficulty in knowing just what response might be expected from a specific treatment and therefore in making reliable ratings. On the other hand, in rating total response to treatment, the clinician might feel free to consider any form of improvement without regard to a supposed causal relationship to a specific therapy. If so, then the reliability of the rating scale should be higher for the total response item than for the specific therapy items, although no data were available by which this speculation might be confirmed.

It has also been our observation that clinicians often place a high value on verbalization of affective material as an indication of positive treatment response. If this cue was operative in our group of clinicians, then we might consider this additional evidence for the theory that work "sets the stage" for incorporating the benefits of other therapies. This interpretation is perhaps warranted by the fact that the work therapy program was designed so that it not only did not encourage verbalization of feelings, but actually ignored and discouraged such behavior. Therefore, the more favorable treatment response on the part of the W.T. participants probably cannot be attributed to any direct training in the types of behavior that would have been likely to impress the staff as indicators of positive treatment response.

In spite of the apparently positive results of work therapy, as rated at time of dis-

charge, the important question is whether or not those subjected to it are able to function differently in the community from those who have not had work therapy. Unfortunately, the effectiveness of most therapies is all too often evaluated within the context of the unreal world of a psychiatric hospital rather than in the family, neighborhood, and job. Future examination of post-discharge follow-up data for the samples included in the present study should provide information on this question at a later date.

Summary

It was hypothesized that participants in work therapy would respond more favorably to other hospital therapies than would non-participants. Responses to five areas of therapy, including group, occupational, recreational, social activity, and over-all response to therapy, were considered. The samples were randomly drawn and assigned to participate or not participate in the workshop program at the time of admission to the hospital. Data were collected from

clinical staff members' ratings of each patient's responses to therapy.

The results revealed a significant difference between the participant and the non-participant group in over-all response to therapy, but no significant differences were found between the two groups in their response to the four specific therapies.

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Robert J. Hartford

The voluntary mental health association: an innovator of services

The voluntary mental health association is uniquely suited, by reason of the roles assigned to it, to engage in the demonstration of innovative mental health services. Five such projects: an after care study; transitional living facilities for newly released mental patients; a day school for emotionally disturbed children; a pre-school for mentally retarded children; and a teacher training program are discussed. Their administration was subsequently assumed by other agencies.

Voluntary enterprise for public good is one of the distinguishing marks of the American national character. Brian O'Connell, Executive Director of the National Association for Mental Health, has described voluntarism as "... a process, born of freedom and sustaining freedom; so diffuse that it accommodates the extremes of our national aspirations and so grand that it includes the disparate pursuits of a thousand different programs." Perhaps the only common characteristic of the more than 100,000 tax-exempt voluntary organizations in the United States is their financial base—voluntary contributions. These contributions are derived either from a variety of

direct fund raising efforts of the organization, allocations from a source of federated fund raising, or a combination of these.

Although initiated and governed by individuals, most commonly a board of directors, the voluntary agency may not properly be regarded as a strictly private enterprise because: 1) it is supported by the community at large; and 2) the agency and its contributors receive tax exemptions and deductions on the grounds that a public purpose is being served by the organization.

Roles of MHAs

In the field of mental health, at least three roles are usually assigned to the voluntary agency.

1. As an agent of social change, the voluntary agency serves simultaneously as a critic and as a prod to the governmental or public sector. In this

Mr. Hartford is the executive director of United Mental Health Services of Allegheny County, Inc., 4026 Jenkins Arcade, Pittsburgh, Pa. 15222.

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very important role, it provides genuine citizen support for improvement of services and standards.

2. The voluntary mental health association plays a vital role in communications—informing the community about the nature of mental health and mental disability and directing citizens to necessary services. The role of communicator includes the vital task of letting the community know where it is failing to provide the needed services to sustain or improve mental health.
3. The third role, which forms the central thesis of this paper, is that of innovator, vanguard or pioneer. The voluntary mental health association identifies a problem and meets it, often with a modest demonstration or pilot effort. When, as a result of these innovative efforts, the public is sold on the need for the program, government or another segment of the voluntary sector receives a mandate to launch a full-scale effort. The voluntary mental health association is then freed to seek out new challenges or solutions to different aspects of the original problem. This pattern can be found throughout the history of voluntarism in America.

United Mental Health Services (UMHS) of Allegheny County is a voluntary mental health association in a large industrial area whose center is Pittsburgh, Pennsylvania. UMHS is a local affiliate of the National Association for Mental Health. It is supported by funds voluntarily given to The United Fund of Allegheny County and allocated through the Community Chest of Allegheny County. UMHS was established in 1959 to serve the people of Allegheny County in those aspects of mental health,

mental illness, mental retardation, alcoholism and other emotional disorders appropriate to a citizen-based organization. One of the objectives spelled out in the by-laws of the organization is "to encourage or conduct demonstration and research projects designed to test new methods and produce new knowledge."

During the brief nine years since its organization, UMHS has conducted studies and projects which have served as prototypes for new or improved mental health services in Allegheny County. Each of these projects has included the active involvement of other segments of the community, public as well as voluntary, professional and lay, individual and organized. Some of these innovations have direct applicability to national and international mental health efforts.

Studies and Projects

The Aftercare Study * conducted in 1963 and 4, was a structured observation of the ex-psychiatric hospital patient as he moved through the then existing aftercare system in Allegheny County. The system was studied on the basis of its measurable features, and empirical material was related to this analysis. The entire investigation was supported by a grant-in-aid from a government agency, the Office of Mental Health of the Commonwealth of Pennsylvania, and a grant from the Maurice Falk Medical Fund, a private philanthropy. It was conducted under the general direction of the Director of the Community Mental Health Program of UMHS and

* Published under the title, *A Study of the Patterns of Service to Persons Following Psychiatric Hospitalization in Allegheny County, Pennsylvania*, by UMHS of Allegheny County, Pittsburgh, Pa., April 1964; Supplementary Report published in October 1964 and August 1965.

staffed by a full-time project director and an assistant and a part-time research specialist. There was a considerable amount of community follow-through on the findings of the study. However, one result of the study was the development of a demonstration project consisting of a constellation of living facilities for persons who have been released from psychiatric hospitals.

Transitional Services, an effort to establish a program of supervised residential facilities which would serve as a bridge from the mental hospital to "normal" living in the "open" community, grew out of the study. It is time-limited as far as United Mental Health Services is concerned—that is, it is the intent of UMHS, after a suitable demonstration period, to integrate the service into the program of an existing mental health agency or facility or to establish it as an independent facility.

Like the study which preceded its establishment, *Transitional Services* has received financial support from sources other than the operating funds of UMHS. The program is funded by a grant-in-aid from the Pennsylvania Office of Mental Health, grants from the Maurice Falk Medical Fund and the Richard King Mellon Foundation, and from fees paid by the former patients who are participating in the program. A detailed description of the program is beyond the scope of this paper; however, an important element of the program is that it has been developed in collaboration with Mayview State Hospital, a large public institution. At this point in time, *Transitional Services* has been in operation almost two years. It is recognized as a necessary component of the community mental health spectrum, and a study committee is investigating several alternatives for permanent auspices of the program.

Poale-Zedeck School was a therapeutic day school for emotionally disturbed chil-

dren established by UMHS in cooperation with a Jewish congregation.

Prior to 1961, day school facilities for severely disturbed children were nonexistent in Allegheny County. In 1960, the public school code of Pennsylvania did not include provisions for special educational programs for children with serious emotional disturbances. The Poale-Zedeck School was a small pilot effort, with three major objectives:

1. to provide educational and treatment services not otherwise available to mentally ill children
2. to broaden research into the field of childhood mental illness and
3. to establish a training center for workers in the field of childhood mental illness.

This project fused special education and group therapy into a total approach. Near the end of the five-year demonstration period, it was formally evaluated. With the need and feasibility for the program clearly established, the Poale-Zedeck School was merged with an outpatient center to form the nucleus of a comprehensive mental health facility for children.

A Pre-School For Mentally Retarded Children was operated as a demonstration project from 1959 through 1964. It was co-sponsored by UMHS and St. Peter's Episcopal Church of Brentwood, a Pittsburgh suburb. The objective of the program was to seek out the trainable child, often regarded by educators as hopeless. Emphasis was on the child's development, rather than education, and on counselling parents to maximize their retarded child's potential.

United Mental Health Services provided the professional team to develop standards, research the testing of children and evaluate techniques and methods used in the pro-

gram. The co-sponsoring church congregation supplied facilities, volunteers and, as the five-year co-sponsorship neared its end, steadily increasing responsibility for financial participation.

The project demonstrated a program that needs to be done under public or private educational auspices. It is now operated totally under the auspices of St. Peter's Church and has served as a model for programs for children with special needs.

Teacher Training is a project in which United Mental Health Services has been actively engaged for almost three years. A training "package" of television tapes, seminars and programmed printed materials is designed to help elementary school teachers distinguish between adaptive and non-adaptive behavior in the classroom. The management of the child with behavior problems and the point at which referral for professional intervention is indicated are integral to the program. The effects of the teacher's attitudes and responses are treated also in the material.

This program evolved from some concepts synthesized within United Mental Health Services, and the funding for the development of the concepts and materials has come from four sources—two governmental grants and grants from two private

philanthropic foundations.* The funding itself is highly significant. The partnership between the public and the private is explicit, and the prestige of the voluntary mental health association as an innovator is clearly affirmed.

At the time of this writing, the materials in this program are being readied for broad distribution as an important tool for prevention and for the detection and treatment of incipient emotional disturbance in children.

Summary

As an agent of social change, as communicator and as innovator, the voluntary agency makes its most productive contributions to the health and welfare of the community. The role of innovator or pioneer in the establishment of new mental health services is reviewed in this paper. The brief descriptions of five special projects of United Mental Health Services of Allegheny County illustrate this function, a necessary role for the mental health association which, by definition, must be in the vanguard of mental health progress.

* Commonwealth of Pennsylvania Office of Mental Health, Pittsburgh Public Schools, Pittsburgh Foundation, Richard King Mellon Foundation.

Robert Allen Simons, M.S.W.

Diagnostic Intake: Variation on a Theme

The author examines group diagnostic intake as a method of partially relieving the problem of long waiting lists. Reflection is given to the significant changes that occurred among the staff responsible for inception of the program.

Many clinics, determined to fulfill the mental health needs of their communities, are vexed by the waiting list. It is a detour that denies those who need help and demoralizes those who are the helpers. Common diagnostic intake procedures in multi-disciplinary clinics involve:

- a. a thorough psycho-social history by the social worker,
- b. an evaluation by the psychiatrist,
- c. possible psychological testing,
- d. a staff conference in which "the case" is diagnosed,
- e. a treatment plan designed, and finally,
- f. the patient being placed on another waiting list.

Mr. Simons is a psychiatric social worker employed by the Santa Clara County Community Mental Health Program in its center for outpatient psychiatric services. His home address is 21416 Bear Creek Road, Los Gatos, Calif. 95030.

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This is thorough, safe and sound, and provides the staff with good clinical experience. However, it often leaves the patient waiting for a long time period.

In addition to patient futility, there are consequences in terms of the staff participant. In **A Mental Health Clinic Intake Policy Project**, Rooney and Miller point out how anxious is the involvement of a staff coping with a community's mental health problems, and how hopeless the experience when these needs are not met.¹ The cold waiting list, inferring, "out of sight, out of mind" is a source of much discouragement.

Conventional procedures further limit representatives of the three disciplines to delineated tasks in predetermined areas. It is expensive and time consuming.^{2,3} It may even be unnecessary, or, at best, redundant. We felt that meeting here-and-now needs could do with less thoroughness as far as history taking was concerned. Emphasis on causative stress agents coupled with fast intervention seemed more appropriate. Serving a low socio-economic segment of the population, we were confronted

with limited sophistication about mental health and poor tolerance of traditional psychotherapeutic assistance.⁴

All these facts influenced our choice of a diagnostic intake approach with, as stated before, a strong accent on here-and-now problem delineation which seemed more acceptable to the population served. A diagnostic intake team composed of a psychiatrist, two psychiatric social workers, and a volunteer worked together. It meant coping with not only a long waiting list, but also a staff's feelings about this waiting list.

Methodology

Those requesting our services do so by telephone or walk in. If it is not a dire emergency, the admitting social worker offers a diagnostic intake appointment. Excluded from this approach are: the obviously disturbed applicants who are seen immediately; applicants who do not accept our diagnostic intake appointments; and illiterates who are given individual appointments. Those eligible and accepting are given a brief explanation of our diagnostic intake procedure.

On the given date between eight and eight-thirty in the morning, applicants come into our clinic and are welcomed by a volunteer staff member who seats them and tells them about our services. Each applicant is given a booklet with questions to complete, a treatment permit to sign, and, if necessary, releases to sign so we can obtain records of prior treatment elsewhere. The volunteer encourages discussion, thereby creating an atmosphere of "you are not the only one who has problems . . . you are not in it alone."

The questionnaire consists of four pages. The first page collects typical fact-sheet information. This serves a two-fold purpose in that it is easy to answer and can calm the applicant who often fears this first en-

counter and it saves him from meeting still another person who collects this type of data.

The second page questions and helps the applicant to outline present difficulties and inquires as to previous counseling. The next page helps him to describe the people significant to him: spouse, children, siblings, parents; his relationships with them, how he sees them, and how he sees himself. The last page explores physical health, incorporating psychosomatics and drug usage. It ends by asking how we can be of help to the applicant.

Upon completion of the questionnaire, the applicant is introduced by the volunteer to the intake social worker and the three sit down in private to discuss the questions answered. Problem exploration, further definition and clarification, treatment possibilities, and the applicant's wishes are then verbalized in a brief interview of about ten to thirty minutes. When the social worker feels fairly clear about the applicant's present problem, causative agent(s), and underlying psycho-social dynamics, a tentative recommendation is made. In cases of gross concern about the applicant's present mental status, the psychiatrist is called in for further exploration. After all of the applicants are seen, the volunteer and the social worker meet with the psychiatrist and, if necessary, the psychologist for: (1) discussion of psycho-social dynamics; (2) diagnosis; (3) design of treatment plan; and (4) planning of follow-up interviews and/or psychological testing. When necessary, we use the MMPI which is administered by our volunteer.

We attempt to leave the applicant with a simplified picture of how we can help him. We tell him what resources in the community he can utilize instead of, simultaneously with, or pending our help, and what he himself can begin to do.

Staff Reactions

Mounting waiting lists of people who need evaluation prior to treatment have a most adverse effect on the clinic staff.^{1, 5} It often seems to result in "blowing up" differences between staff and administration. Meaningful change, action initiated by those staff members facing the issue, coupled with administrative support and backup create an alive, cohesive clinic atmosphere.

Change—in this case creating a different diagnostic intake approach to co-exist with the traditional one—can cause stiff resistance. We feel that because the change meant dealing constructively with a painful issue—the waiting list—the opposite reaction occurred.

Our first attempt was a diagnostic intake composed of four applicants, involving one social worker and a psychiatrist. Soon another psychiatrist suggested that on another morning she see children—age range four through eleven—as a group in the playroom while their parents and other adults were subject to the diagnostic intake. Then a psychologist offered his services as a consultant on where and how to utilize psychometrics. Another social worker joined our project. Thus we could enlarge our diagnostic intake from four to fourteen applicants.

When many of the just-screened applicants needed emergency care, crisis treatment groups were created by two members of the social work staff. This enabled us to see an applicant in the a.m. and have him begin treatment later that same day.

A volunteer came into the picture. She welcomed the applicants, told them about our clinic, handed out the questionnaires, introduced the applicants to the evaluating social worker, and was present throughout the interview. Since the volunteer has had

treatment experiences, she spoke of them to the applicants to help them lose initial fear and to begin formulating their own questions. The volunteer joined in the diagnostic conference and has been able to give the professional staff most astute and helpful observations.

Role blurring and role change took place among the diagnostic intake team of psychiatrist, psychologist, social workers, and volunteer. At times, the psychiatrist would assume social worker functions, such as suggesting what community resources could be utilized. The social worker would at times propose the applicant's diagnosis.

Summary

Use of diagnostic intake groups is no novelty. The literature reports on several of such groups.^{2, 6, 7, 8, 9} The emphasis of such treatment modes was to explore solutions to the problem of ever-growing waiting lists and how the diagnostic group intake affected the people on these lists. However, while initially we seemed to be making a dent in the list of those awaiting work-up and evaluation, this no longer holds true. We could postulate that by meeting a need, we have created more need and demand for our services.

In contrast to other articles on diagnostic intake, we wish to stress clinic staff reactions. We are now working harder, doing more and enjoying it more. A four-hour morning enables us to see fourteen applicants requiring four hours of non-paid volunteer time, six hours of social worker time, one and one-half hours of psychologist time, and one and one-half hours of psychiatrist time. We have created a determined, cohesive, enthusiastic, communicating, and creative clinic staff. Former rigidities about treatment, reinforced by failure to meet the applicant's needs, are diminishing. A

meaningful search to reach the applicant in his territory and on his terms has begun. An example might be our further research in using volunteers beyond the traditional fund raising, coffee-pouring level. We are about to train one of our volunteers in doing dictation, the plague of many a social worker, direct from the completed questionnaire. We also have rewritten our original questionnaire for the fourth time. It now reflects contributions of the three disciplines collaborating and cooperating in the diagnostic intake process. This could only come about after a closer working together and a truer understanding of how each discipline approached the diagnostic intake process. Efforts like this have meant increased staff morale.

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Jacob Christ, M.D.

Shirley Goldstein, M.S.S.

Four techniques in dealing with psychotic disorders in the outpatient clinic

The authors outline four major modes of dealing with the problems of the psychotic outpatient in a community oriented clinic setting. Supportive methods can be carried out either individually or in a group setting. Acute crisis intervention, possibly involving hospitalization, is best carried out within the context of a treatment plan and with the family. The interactional setting, often the family of the patient, provides the most important clues as to the meaning of a psychotic syndrome. Assessment of the interaction allows proper planning for treatment, while the assistance of close relatives in the treatment situation often permits progress which otherwise could not be accomplished.

Introduction

With the great expansion of psychiatric outpatient services throughout the country within the last five years, many psychotic patients have approached professional workers for help and very likely will continue to do so. The authors felt from the beginning of the functioning of the McLean Hospital Outpatient Clinic five years ago that the conventional techniques of once-a-week psychotherapy and long waiting lists would be insufficient to deal with the psychotic patient. This article presents some suggestions for using various techniques but also calls forth a different point of view which one may apply to the treatment of

the psychotic patient as he presents himself in an outpatient setting.

Harry Stack Sullivan¹ as early as 1930 concluded that not sick individuals but complex, peculiarly characterized situations were the subject matter of research and therapy. This is to say that Harry Stack Sullivan considers the disease schizophrenia not as something residing in the patient but as a particular type of situation prevailing between the sufferer and his environment.

Techniques

Within this ideological framework, the following major modes of intervention with schizophrenics will be discussed: supportive treatment over a period of time by individual methods; group psychotherapy and group supportive methods; interventions in the acute stage of a psychotic disorder; and treatment methods involving spouses and/or other family members.

While regular psychotherapy groups tend to be insight-oriented and based in general

Dr. Christ is the psychiatrist-in-charge; Shirley Goldstein is the casework supervisor at the McLean Hospital Outpatient Clinic, Belmont, Massachusetts 02178.

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on an analytic model, such an ex-hospital group may be more geared toward sharing and understanding ego functioning.

Interventions in the Acute Stage. The characteristic situation here is most often a suicidal threat and occasionally an acute confusional state. Seen from an individual point of view, the question of hospitalization for the sick patient is a priority raised when an outpatient clinic is confronted with an intake call, referral, or walk-in involving these problems.

Many thoughtful diagnosticians will, after having seen a patient, still be unsure as to whether the patient is or is not going to injure himself. Predictions of that sort are almost impossible to make. A view that severe disorders, and particularly suicide, in some sense bespeak situations rather than sick patients, might let us approach the problem from a different vantage point. The clinic has adopted a policy that where an emergency of one sort or another is present, rather than relying first and foremost on a diagnostic opinion about the patient, we search for a person who is close to the patient. In this way, we might gain an idea of the situation. Our first question, then, would not be necessarily that of suicidal patient versus non-suicidal patient, but "Where is a close relative of the patient?" Quite regularly, when the accompanying person is interviewed together with the patient, one gains some idea about their interaction, and one often comes to see at least some of the reasons why the patient became ill at this time. If hospitalization is indicated, a supportive person will be there with the patient. Hospitalization can then become an agreed upon decision rather than a judgment inflicted by a seemingly omniscient doctor.

Crisis Intervention and Treatment Involving Relatives. An example of crisis intervention involving a number of rela-

tives will illustrate the point of assessing the situation as a whole.

In this case a 32-year-old mother of three children presented herself as a case of a severe suicidal and also possibly homicidal threat. She came in a state of severe agitated depression, afraid she might kill herself together with her youngest two-year-old child. She told us that she had had a fleeting infatuation two years before with a man with whom she worked in a factory. In order to restore the good relationship with her husband she became pregnant and had a child. But instead of restoring the marital equilibrium, she felt even more guilty and her depressive symptoms increased, eventually culminating in wishes for her death and the death of this particular child. Her husband had increasingly withdrawn, spending most of his affection on one of the two older children, not caring for the little one. On a first approach the matter of hospitalization had to be discussed in the presence of both husband and wife. They agreed for the first time with each other in deciding to discard the idea summarily and while the possible consequences of their joint decision were outlined to them, they felt that matters would remain under control. They had a good point, for it became evident in that interview that the wife's mother might be the only one to contain the patient in her present situation. The patient herself, in a subsequent interview, requested that the mother be seen in the clinic. In a joint interview with the patient it could be observed that mother, who had herself suffered considerable sickness and deprivation, had become hardened by her life experience and was now just as hard and determined in getting her daughter through her ordeal. Once we had seen and agreed in the interactional setting that the mother could be counted upon, we allowed the patient to remain out of the hospital and instituted anti-depressant medication and supportive casework therapy. The husband was also to be seen in order to get him once again involved with her.

Individual Supportive Techniques. These are most often applicable when the patient

would appear to be in a more-or-less latent stage of his psychotic disorder. They are possible with hospital-discharged schizophrenics who as yet have not found a way of fitting into society in a manner acceptable to themselves or their environment. The patients' complaints may be of many sorts, from being out of a job to experiencing tensions, anxieties or even hallucinations. It is of paramount importance in these more chronic situations that the patient be given a regular, if perhaps not too frequent, opportunity to air his complaints, seek advice and find a consistent and yet alive relationship with a therapeutic person. Most often such patients may be seen on a once-a-week basis while the relationship is established, and then spaced to once in two weeks or once a month. The interaction with the therapist will include concrete advice on matters of job placement, etc., in line with a maxim of treatment, namely the importance of helping the schizophrenic to "think straight", or, in different words, regain a sense of reality. Sometimes a drug regimen may be added to such supportive treatment. The therapist is well advised to consider the patient's anxieties and help him identify his particular useful and not so useful coping mechanisms.

One of the ever present issues is the danger of exacerbation of the clinical picture, due either to outside stress or to the intensification of the relationship between patient and therapist, which almost universally is frightening to the psychotic patient, and sometimes frightens the therapist as well. The supportive therapist must recognize when the patient requires rehospitalization. One should allow the patient to make use of hospitalization as needed, rather than insist on "fighting it through" when this is possibly beyond the resources of the patient. A carefully planned hospitalization is likely to be more therapeutic

than a struggle to the last ditch, where a patient literally has to go downhill, reaching the point where he has no alternative but the hospital. An anti-hospital bias on the part of many treating professionals is by no means rare. The idea of having one's own patient committed to a state hospital is appalling to many workers in the field. Yet, looking at the issue objectively, the hospital is there for a purpose and if hospitalization is approached unambiguously and realistically with the patient, the hospital will serve its therapeutic end that much better.

Group Treatment of Psychotic Disease in an Outpatient Setting. While many outpatient clinics will not accept ex-hospital patients for treatment, those who do may find that to give individual support to all of these patients becomes a very time consuming matter. Rehabilitation experience with ex-hospitalized patients indicates that a group setting can be particularly supportive to patients who find themselves misunderstood or different in society at large. A communality of feeling rarely fails to develop in such a setting and while perhaps such a psychotic outpatient group may not yield spectacular results in terms of developing intrapsychic insights, it may well be significant for its cohesiveness and its supportive effect on the members.

A 45-year-old ex-registered nurse had spent more than 20 years in a state hospital, interrupted by some short-lived attempts on her part to live with relatives of hers. Characteristically, at the slightest sign of trouble the relatives brought her back to the hospital. She approached the clinic for help with the fear that she might soon have to be hospitalized again. After some hesitation she fitted herself into a therapeutic group. Three years later she had not only stayed out of the hospital, but had also secured a position, reinstating herself as a functioning registered nurse.

Availability of the family and concrete

negotiations for support appeared to be the crucial intervention which saved this woman from hospitalization and kept the family intact. Ideally, a team of workers should be available in order to carry out the salient family interventions. Flexibility in arranging joint or separate interviews as needed is equally necessary.

Discussion

While the foregoing views and the illustrative examples do not in themselves constitute a unified theory about the nature of psychosis, it seems nevertheless fitting to present in somewhat abstracted form the pertinent assumptions underlying the proposed innovative ways of dealing with psychotic patients.

1. The authors see psychosis as a profound disturbance in the functioning of the ego as psychoanalytic theory stipulates. They attribute value to supportive therapy, be it in a group setting or individually, and they do not shy away from active intervention and environmental manipulation.

2. Perhaps more important is the consideration that the human relations which the psychotic patient has or creates with his environment, are most often of a fundamentally altered nature, from those of healthy or neurotic people. We refer here to the nature of object relations as one might observe them in hospital or milieu therapy with psychotic patients. It is an easily ascertainable, although perhaps under-emphasized fact that the schizophrenic patient distinguishes himself by an extraordinary concreteness in his daily endeavors, such as complaining about the minutiae of hospital management, food service, restrictions, etc., whereby the intensely personal aspect of his illness or general impairment goes by unnoticed.

3. The transference expectations of the schizophrenic are therefore often at the

same time very simple and very exaggerated. He comes with an urgent piece of business at hand that he wants the doctor to do for him. He may seek the removal of a person who creates pain, may want to get rid of certain physical feelings that are bothersome or may need relief through financial or other support. No therapist is likely to understand right away what the potential action is which the patient has in mind, as he disguises his often unacceptable intent into a form he judges suitable for a professional helper. The family situation brings both patient and therapist closer to "where the action is" and therewith to the meaning of the symptoms.

4. In dynamic and structural terms, we often encounter a fragmented ego that relates to people not as total objects, but as part objects. Part objects appear as tools, mere functions, or means to an end, where the person has lost his personal characteristics, become a "thing", an idea, a helpful or hindering feature for intended action. The self-image, a result of healthy identifications, is often almost non-existent, except through the view of others' needs, and identifications are equally partial as are object relations. Denial, projection and distortion in the interest of the maintenance of an existing relationship, even if it is an unsatisfactory one, are frequently used mechanisms. The advantage of the interactional setting is that it provides the observer with a visible interpersonal reality, within which he can perceive the strongly charged agenda of the patient, his action potential, the "real business" of the schizophrenic.

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Murry K. Cunningham, A.C.S.W.

Eileen A. Koehler, M.S.

Roy F. Schmidt, A.C.S.W.

From Psychiatric Hospital To Nursing Home

The authors describe a program of a Veterans Administration hospital which makes use of community nursing homes for physically disabled patients who need nursing care and who have a psychiatric diagnosis in remission. One hundred patients were placed in ten nursing homes under contractual agreements with the VA. The average age of the patients was 66; some had been hospitalized for as many as 44 years. Beds released by these chronic patients have allowed the hospital to treat more acute patients. Proper implementation of the program had a positive influence on the opinions of staff, relatives and patients.

The Veterans Administration Hospital in Northport, Long Island, New York, a 2032-bed psychiatric hospital, released 100 beds previously occupied by chronic long-term patients needing skilled nursing care. The beds so released were used by approximately 400 patients for treatment of acute phases of their illness. These beds were made available by the Veterans Administration Contract Community Nursing Home Care Program, which became operative on July

1, 1965. This program authorizes the transfer of eligible veterans from the VA hospitals to community nursing homes, with financial responsibility being assumed by the Veterans Administration for a period of six months. The primary purpose of the program is to aid the veteran and his family in making the transition from a hospital to the community.

Prior to the initiation of this program, many of these chronic patients could not be moved and were viewed by the staff as more or less permanent residents. Their continued hospitalization was said to be due to lack of nursing home beds, funds and/or families to care for them.

For this program to operate, the staff, patients and relatives needed reorientation

The authors work at the Veterans Administration Hospital, Northport, Long Island, N. Y. 11768. Mr. Cunningham is the assistant chief of Social Work Service, Miss Koehler is the Public Health Nurse Coordinator and Mr. Schmidt is a social worker assigned to nursing home and rest home placements within the Community Placement Program.

to think in terms of discharge goals. The Veterans Administration's willingness to pay for nursing home care helped both staff and patient to recognize that he would not be abandoned once placed and would continue to receive excellent care in the community. The relatives accepted this plan for several reasons: community follow-up is provided by the Veterans Administration; and the relatives are given a reasonable period of time with assistance to evaluate the veteran's adjustment in the community.

Successful placements changed the attitudes of ward personnel, relatives and patients. This resulted in increased referrals from the wards and requests for this service from the relatives. The referral of a veteran for nursing home placement originates on the ward. The physician, nursing personnel, social worker and psychologist all play a part in evaluating the veteran. Primary importance is given to the patient's physical disability which requires nursing care for convalescence, rehabilitation or for continued care for a minimum of two months. This evaluation ends with the staff action approving Maximum Hospital Benefit (MHB) discharge to a community nursing home. Patients requiring extensive medical care or x-ray and laboratory services are excluded from this program.

Placement of Patients

During the time this program has operated at our hospital, placements have been made from all areas of the hospital; that is, from the Medical, Surgical, Continued Treatment and Acute Treatment Services.

Once MHB discharge is approved by staff action, the patient is evaluated further by the social worker, who tries to place him in a home that is compatible with his behavior patterns and his physical limitations.

A nursing assistant accompanies the patient to the home. All pertinent information and records go to the home. Following the veteran's placement, regular visits are made to the nursing home by the social worker and the public health nurse coordinator. Periodic visits are also made by other designated personnel such as Medical Administration Division and Engineering personnel.

The placement of these chronic patients in nursing homes has a stimulating effect on the ward personnel. They see veterans successfully placed in the community; they see a turnover rate which did not exist before; they become aware of better utilization of available treatment personnel.

In our Chronic Medical Building alone there was a dramatic increase in the discharge rate. In the 18 months prior to initiation of this program, the discharges from this building were 13, none to a nursing home. In the 18 months* the Community Nursing Home Program has operated, the discharges increased to 80, with 39 going to nursing homes. In one of our Chronic Neuropsychiatric Buildings, the discharges during the 18 months preceding the program were 36, none of whom went to nursing homes. Following the initiation of this nursing care program, discharges from that building totaled 102, with 32 going to nursing homes.

VA Role in Nursing Home Program

The Veterans Administration's nationwide entrance into the use of community nursing home programs has many ramifications: (1) the community nursing homes are required to meet VA standards; (2) the nursing homes must make reports and develop a reporting system; and (3) the reports supplied by VA Hospitals give the

* As of July, 1968.

nursing homes a helpful guide; (4) the Veterans Administration has made contractual agreements with the nursing homes concerning rehospitalization; (5) the nursing homes have consultants to turn to (the VA social worker and public health nurse coordinator); (6) The Veterans Administration's experience with this program provided valuable assistance to the Social Security Administration in implementing its nursing home program under Medicare; and (7) The Veterans Administration is one of the few nationwide agencies keeping statistical information concerning nursing homes.

At the Northport Veterans Administration Hospital, the program indirectly helped veterans in the community. For instance, the waiting list diminished from 1200 to 665. This is due in large part to those beds vacated by 100 chronic patients being used to admit other veterans needing care.

More important may be the impact this program has for psychiatric hospitals throughout the nation. The formerly active psychotic whose symptoms retreat into partial remission but for whom aging and chronic brain syndrome begin to appear, and the newly admitted elderly chronic brain syndrome patient who after examination indicates need for nursing care but not extended hospital care and supervision are both logical candidates for community nursing home care.

It has been the experience of the Veterans Administration Hospital at Northport, and others,¹ that many patients in psychiatric hospitals can be cared for in community facilities that are geared to their specific needs.

The following statistics concern the initial 100 veterans placed from the Veterans Administration Hospital, Northport. The age range is 42 to 88; the average being

66. The average length of continuous hospitalization is 5,989 days (16½ years). The range of hospitalization is from 14 days to 538 months (44 years and 10 months). The years of continued cumulative hospitalization are: Less than one—22; 1 to 5—22; 5 to 10—5; 10 to 15—4; 15 to 20—4; 20 to 25—6; 25 to 30—7; 30 to 35—14; 35 to 45—16.

The per diem cost per patient is \$15.05. To keep the 100 patients in the hospital for six months costs \$1,505 per day. For them to remain in the community for six months would cost the Veterans Administration \$1,050 daily. The difference is \$455 per day. Thus, the fact that 100 patients remained in the community for six months resulted in a savings of \$83,265.

The following case summary gives an idea of the type of patient who makes use of the nursing care program:

Mr. C is a 51 year old man, admitted to a psychiatric hospital for the first time in January, 1966. History revealed that he had suffered a cerebral vascular accident in September, 1965, resulting in a left hemiparesis. It also had its effect upon his emotional health to the extent that he was unable to manage either on his own or with help of relatives. Following hospitalization, the patient improved; but the relatives began vacillating between guilt at initial and continuing hospitalization and relief at having the hospital assume responsibilities for his continued care. Through support and consultation with the hospital team, the relatives and patient were able to accept the desirability of post-hospital care through nursing home placement. As a result of his period of nursing home care and evaluation, the relatives and patient began to recognize the realistic limitations of his physical disability and the response this evoked in them. They were able to plan

and carry through post-VA-sponsored nursing home care in a facility convenient to them at a cost appropriate with the veteran's financial resources. Before this inception of VA-sponsored nursing home care and encouragement toward community placement, this patient could easily have become one of our many chronic, medically-infirm patients.

The effects of this nationwide program on one large psychiatric hospital in the Vet-

erans Administration system can be duplicated in psychiatric hospitals in our 50 states. It is an effective means of utilizing existing community facilities to help patients in their transition from hospital to the community.

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*Bloody red flowers,
When do I die?
Green ivy,
Growing over my grave.
Iron gates,
Protect me,
From summer,
From autumn,
From the thorns of roses.*

—Annie Wu

Stephen Bernstein, M.D.

Joseph Herzberg, M.D.

Small Group Experience With Psychiatric Aides

Work with small groups of aides, outside the regular staff meeting format, seemed to have improved communication between aides and other staff and increased effective interaction with patients.

Work in the function of milieu therapy in the treatment of hospitalized patients has stressed the influence of numerous aspects of staff-patient relations: staff roles, interaction, communication, and training, along with the general needs and rewards sought by different staff members.^{1, 2} In this paper, we shall describe some of the techniques of group experience found useful in the training of psychiatric aides and in the encouragement of these aides to do the "ego work of the milieu." The effects on a psychiatric ward of small group experience with psychiatric aides will also be discussed.

At the time this work was done the authors were residents in psychiatry at the McLean Hospital, Belmont, Mass. Presently they are with NIMH, where Dr. Bernstein is program head of the Early Clinical Drug Evaluation Unit of the Psychopharmacology Research Branch and Dr. Herzberg is a clinical associate in the Adult Psychiatry Branch. Requests for reprints may be addressed to Dr. Bernstein, Room 10 C 01, NIMH, 5454 Wisconsin Avenue, Chevy Chase, Md. 20015.

Review of Relevant Literature

Sullivan³ described the uniqueness and effectiveness of using non-professional personnel in the construction of a ward social-therapeutic structure and pointed out the advantages of confronting his patients with a less stratified staff. Subsequently, Jones⁴ and the Cummings⁵ emphasized various social and interactional methods of psychiatric treatment. In the latter's work, Ego and Milieu the psychiatric aide is described as a "facilitator and guide" who is the first line of contact for the patient, a liaison with the nursing staff, and a therapeutic agent in his own right. The Cummings stress the vulnerability of the aide without support and encouragement from nurses and doctors; they point out that the aide should be taught how people interact in groups and that he should "learn to recognize and experience group pressures and group support in a group-therapy class."

Interest in the motivation and function of the psychiatric aide has stimulated investigation into his general personality structure and has inspired seminars on his role, such as the 1960 Norristown State Hospital Seminar.⁶ At that seminar, current limitations on the "maximum utilization of the therapeutic potentialities of many aides" were observed. Also noted were pressures on the aide because of lack of certainty in his role, lack of social

status, and lack of satisfaction in both intrinsic and extrinsic rewards in his job, leading to job dissatisfaction and lack of communication. Rewards were seen as an important factor, with aide training by frequent contact with doctors and nurses being a type of intrinsic gratification. Meetings were suggested in which "the staff, including the aide, is encouraged to talk about their feelings toward the patient, toward each other, and toward the leader. The primary advantage of this training device is that it permits immediate relationships on the ward at the time that the anxiety is at its height. Classroom problems, by contrast, are far too abstract and personally uninvolved to create interest and to motivate a search for solutions."

Role ambiguity and its effects on both staff and patients were noted by Harris and Johnson,⁷ who saw clarification of roles through regular group meetings of the psychiatric aides with experienced group therapists.

Purpose of the Present Study

The use of group meetings with psychiatric aides described here grew out of a general feeling on a particular psychiatric ward that a failure in the lines of communication had arisen that could be traced, in part, to the inability of the different levels of staff members to express openly their feelings, insights, and information concerning current patient treatment and reactions. Ward meetings were held once a week with the staff and patients, and the professional nursing staff met weekly with the psychiatrist in charge of the ward. However, the psychiatric aides were noted to be somewhat discontented, and resistant to attending and openly discussing matters at staff meetings.

In addition, the ward was becoming one for adolescent males only, with inherent special problems. It was especially important to open up all possible channels of communication because of: 1. age-related character problems; 2. the necessity of setting consistent limits; 3. the tendency of adolescent patients to divide the staff; and

4. the fact that all of the aides were male and close in age to the patients, with consequent problems of aide identification with patients.

It was hoped that group meetings would give the aides more insight into their role and clarify their position in the ward structure. Such meetings would help them express their feelings and realize, not only that these were normal, but that they could be useful on a conscious level in dealing with patients and in communicating with the staff. It was felt that these meetings would encourage increased group identification, increased sensitivity to patients' needs, pride in work and a realization of the effect of the aide's relationship to the patients. It was also hoped that a long-term effect of this program would be a decreased turnover in aides.

Technique

For a twelve-month period the aides met weekly for 50 minutes during the change-over period between the day and evening shifts, so as to encourage the attendance of more members. The group, consisting of five male aides, was formed with the cooperation of the psychiatric and nursing staffs. It met on the ward, in the closed patients' dining room, with a resident psychiatrist. During meetings aides were excused from all other functions. The meetings were quite informal, taking place around a table.

Initial meetings centered around specific problems with certain patients. Gradually this extended to discussions of feelings about patients. Feelings of hostility toward patients were discussed because of their obvious presence. Guilt about such feelings, if undealt with, could interfere with proper management of patients due to oversolicitousness or increased defensive aggres-

sion. Patients' actions unacceptable to the aide, such as physical aggression, discussion of sexual behavior, verbal abusiveness, and regressive behavior, were aired. These actions were seen in part as the patient's attempt at inducing interpersonal distance. Means of overcoming this were discussed.

The leader found it useful to acknowledge that he, too, had feelings about patients, that it was helpful to express and discuss these, and that they could be used to benefit the patient. The idea that a sudden change in one's own feelings about a patient might indicate a change in the patient's mood helped the aide to see that his feelings were an acceptable area of discussion. After approximately three months the aides were increasingly able to express themselves in staff-patient ward meetings and weekly staff conferences.

Discussion then turned toward raising the aide's conception of himself as a useful part of the treatment team. The group leader found it useful to point out the uniqueness of the aide in the therapy team—the fact that he is probably the most “natural” member of the staff, unencumbered by the psychiatric jargon of both nurses and psychiatrists, with “normal” patterns of activity and a good ability to become close to the patient. It was hoped that the aide would see himself as similar enough in many respects to relate to the patient, but also as stable enough so that interaction with patients would not be threatening.

Further discussions during the second three months concerned many of the difficulties of being a psychiatric aide, such as low pay, lack of social status, and low position in the staff hierarchy. Discussions centered on what could be done about this. Suggestions by the aides included a formalized training program leading to a certificate or diploma as a psychiatric tech-

nician, which would in turn tend to upgrade the aide's status.

Prior to the group leader's leaving the ward at the end of six months, the group requested that the meetings continue with the new resident. During the transition period, several meetings were held between the old and new group leader to discuss the history of the group, its stage of development, and its goals.

During the second six-month period, increased effort was made to communicate ideas discussed in the aides' group in both staff and patient meetings. This was generally done by the aides themselves. The group leader provided support but remained neutral in discussions outside the group. He did, however, encourage overt dealing with issues which involved both aides, patients, and other staff, to avoid a split between the aides and nursing personnel. Concomitant meetings with the nursing personnel kept the nurses from feeling “left out” so that they did not sabotage the aides' group. It was noted during this period that when an effort was made by the leader to hold the group meetings off the ward, in his office, resistance to attendance increased on the part of the aides.

Throughout the course of the group sessions, various maneuvers to encourage group identification were used, such as referring to the meetings as “the aides' group” and pointing out similarities in the circumstances and feelings of the different members. It was not the aim of the group to teach group process to the aides. Moreover, it was noted early that group-process interpretations were met with great resistance because, presumably, the aides felt that they were being treated as patients. For similar reasons, individual interpretations concerning unconscious content were not made.

Results and Conclusions

It is difficult to establish a definite causal relationship between the group meetings and subsequent communication and participation by the aides with both staff and patients. However, a definite temporal relationship was quite evident.

Soon after the onset of the meetings, the leader noted a definite increase in the willingness of the aides to participate in the community meetings with the patients and especially in the staff meetings. Increased staff cohesiveness was soon seen when the aides initiated several useful and constructive social functions for the staff. Three of the unmarried aides decided to room together, which was seen as an effort to increase the aides' own group unity and mutuality.

There was also noted an increase in patient self-organized group activity with aide supervision. Aides initiated events such as movie and dining outings, cookouts, ski and canoe trips, and ward window washing and planned renovations. The aides and the nursing staff cooperated in making daily entries in a "group activities book" which was helpful in monitoring individual patients' social progress. It seemed that the aides had developed more sensitivity to group experience and wished to organize the patients into groups as well.

The ward psychiatrists observed after six months that the patients seemed to be taking more initiative in their own groups to set limits beyond which adolescent behavior would not be tolerated. This was interpreted in part as a result of an identification with the aides' group unity and cohesiveness. Patients' rude behavior toward staff and female student nurses was no longer tolerated by their peers. Perhaps out of increased aide involvement with them, the patients gained a greater respect for other

staff; this seemed to parallel the aides' increased sense of cooperation with other staff members.

The aides made several concerted efforts to improve their bargaining power with the nursing administration. After they had conceptualized their ideas of their function into a paper, they delivered it to one of the weekly staff meetings and invited the nursing director to attend. They subsequently approached the nursing director to inquire about the possibility of formal aide training. Because of the respect they had received on their own ward, their discussions with administrative personnel were taken quite seriously.

Five regular members of the aides' group became leaders among all other hospital aides. They gave direction and support to the general desire among the hospital aides to improve aide training and position; they provided appropriate and effective channels to make such appeals for better salaries, more consistent and equitable working shifts, and permanent milieu placements rather than the generally unpredictable "floating" known to the hospital administration. Because the other aides looked to this group for leadership, the aides' group seemed to feel an increased self-esteem.

With their increased openness, the aides' group discussed the assumptions they thought the nursing staff had been making in their assignments: 1. An aide is an interim employee and hence not sufficiently motivated or involved in his ward milieu to warrant insuring permanent ward assignment; 2. The patients are not involved enough to suffer in their treatment program if an aide is "floated", or transferred permanently. However, as the aides gained recognition of their own value, they realized that these assumptions were incorrect. In several cases, they succeeded in having certain of their members permanently as-

signed to one specific ward where they had established rather important relationships.

Numerous cases of increased aide involvement and intervention with patients occurred. In one instance it was mentioned to an aide that an adolescent patient's violent outbursts had been refractory to intervention in the past because he sensed no one listened to him. This remark produced unexpectedly rapid results in one aide who established an alliance with the patient.

On another occasion, the psychiatrist mentioned that a patient's sensitivity to remarks about his appearance was related to an eye immobilization operation. This seemed to increase the aides' appreciation that they should be recipients of selected information about patients if they were to work effectively with them. This resulted in a request by the aides that they be given certain pertinent information about the patients with whom they were dealing. The request was granted, with good results.

Another result was an increase in both the quality and quantity of aides' entries in the nursing notes. These entries were particularly useful during the initial evaluation of several patients when around-the-clock viewpoints were valuable.

We feel the advantage of small group

experience in the education of psychiatric aides is quite clear. We have seen increased aide participation and communication, increased total staff cohesion, increased closeness to patients for purposes of patient identification with aides, and increased group cohesion in the patients. Finally, formation of subsequent aides' groups on other wards has proven that these results are reproducible and beneficial.

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Gary A. Crow, M.S.W.

Interagency pooling of resources to establish new services

A project undertaken by three community agencies in Delaware, Ohio, is presented as a workable idea for a community with limited facilities and resources. The project goal was to provide group services to the Children's Home of Delaware. Processes leading to identification of the need for group services, gaining support from the interested agencies, developing the machinery for providing the service, putting the service into operation and solving problems caused by lack of communication are discussed. It is recommended that communities with limited resources combine staff members to form new service units.

Through the leadership and coordination of the Delaware County, Ohio, Mental Health Association, several agencies were brought together monthly for in-service training and general discussion with the staff of the Children's Home of Delaware (CHD). One result of these discussions led to the Central Ohio Mental Health Clinic and Guidance Center (the Clinic), and The Methodist Theological School in Ohio (the Seminary) jointly considering the need for services at CHD.

CHD is a private custodial institution caring for about forty dependent and neglected children ranging in age from about five to eighteen years. It has no professionally trained staff, provides congregate living

Mr. Crow, a psychiatric social worker, is on the staff of the Central Ohio Mental Health Clinic and Guidance Center, 210 West William Street, Delaware, Ohio 43015. He is also on the faculty of the Methodist Theological School in Ohio at Delaware.

in a very old building not designed as a children's home, and experiences much difficulty due to, among other things, limited financing. CHD is administered by a lay board, and does have the benefit of several very concerned and interested people working for it.

The Clinic is a public-private agency with a professional staff of four; a psychiatrist director, a psychologist and two social caseworkers. It serves as a multi-purpose, outpatient, psychiatric clinic serving children and adults. Among other things, it offers limited psychiatric service to CHD.

The Seminary is a three year school preparing men and women already holding undergraduate degrees for the ministry. Its pastoral care (PC) department was involved in the monthly meetings noted above and became one of the primary agents in the project.

Identification and Documentation

CHD, as a custodial institution, offers no direct counseling or other services related to the emotional and social growth and development of its boys and girls. Unless some specific problem develops, the children are, for the most part, given good custodial care and little else. They have little voice in the institution's program and policies, have fairly limited relationships with the staff, have minimal supervision, and little opportunity for healthy growth experiences within CHD. If specific difficulties arise which are not quickly alleviated, the child or children involved are usually referred back to their home welfare department or to the Clinic. The backgrounds of virtually all of the children are socially and emotionally unstable and replete with "pathogens" as Dr. Hugh Missildine uses the term in *The Inner Child of Your Past*. These two facts seemed to mean that the children were, almost by definition, in real need of positive mental health services. These services would apparently need to be directed toward the healthy social and emotional growth of the children. A review of relevant literature as well as consultation with the Clinic staff and The Ohio State University School of Social Work confirmed this observation, leading to the goal of providing some direct social services for the children.

Due to very limited financial resources, and the shortage of professionally trained people, it was felt that the only feasible approach would be to provide some type of small group services for the children. So as not to get bogged down in social group work literature and the techniques of obtaining professional consultation, suffice it to say that the validity of the small group approach in reference to the children's documented needs was similarly documented. On the basis of this, the goal was, therefore, modified so as to direct efforts

toward providing small group services for the children on some kind of a regular basis.

Combination of Manpower

Considering the limited availability of professionally trained people (the Clinic staff) and the fact that there was apparently no money for such a project, it appeared destined to go the way of many bright ideas. The Seminary, however, saw the project as a possible educational opportunity for a few of its PC students. It was willing to provide eight students for seven months on a weekly basis if qualified instruction and supervision could be obtained. It was also willing to provide some money for this purpose. The Clinic was willing to provide some staff time to the project, and the CHD staff wanted it for the children. It now seemed that there was a way to do it.

This writer, a social caseworker and a member of the Clinic staff, was asked to instruct and supervise the PC students under the Seminary faculty member responsible for the PC course. Similar documentation procedures as noted above supported the validity of doing this. With a workable way of doing it in hand, the project had to be taken to CHD staff and board for final approval.

Presentation and Interpretation

During the foregoing steps, the Clinic social worker, the Seminary PC instructor, CHD superintendent, and the president of the CHD board of trustees were directly involved and consulted. It would, therefore, seem that presentation and interpretation to the CHD staff for acceptance and continuing support, as well as to the CHD board for final approval would be a smooth process. At the time, this appeared to be the case. As the project progressed, however, it

became increasingly clear that this apparently small step was the key to success or failure, assuming that the essential inter-agency cooperation had been established.

Let us digress long enough to conceptualize the working model: A) CHD—4 groups of eight children, B) The Seminary—8 PC students—2 leaders for each group—1 PC instructor-coordinator and C) The Clinic—1 social worker to supervise and instruct through general concepts. With the weekly group meetings to be held at CHD, and using the classical "internship" or "agency laboratory experience" pattern or model, it seemed as if it should be smooth sailing.

Now let us look at the hangup. Even though the CHD staff and board president (who has broad authority to act and react on behalf of the board itself) saw the project as worthwhile and "good for their children," it became apparent that they were unclear about what was; (a) the central purpose of the groups, (b) their responsibility to and within the project, and (c) what was being done to and/or for their children. Attempts to avoid over-explaining and being overly abstract and theoretical, resulted in problems. The lesson was learned that all of the relevant theory and concepts must be laid in the middle of the table where all can see. It then becomes the professional's responsibility to put them into words or verbal ideas which all can understand and accept. This is now seen as a necessary base of communication and, perhaps more importantly, the foundation of trust. One example may serve to illustrate the point.

Early in the group experience, the children started using "what their group leaders told them" as justification for ignoring CHD staff and rules. This culminated one night in a mass rebellion which frightened the two supervisors on duty. Their anxiety aroused, they carried this through channels with the movement picking up anxiety as it went. By the time it got to this writer, it had generated into "Those students have got to go."

In clinical work, it is frequently seen that parents are "played off" against each other; and in the light of day, the staff was able to see this. The main operative factor was an uneasy distrust of what was being done "to" their children. When this point was clarified and further discussed, the problem dissolved.

As our experience continued, the above process needed to be taken one step further. This step is, in retrospect, seen as basic to the success of the project, and as one which should have been given central importance from the outset.

CHD Staff Involvement, Participation, and Responsibility

Before addressing this area directly, let us note a related oversight in the project. CHD may be seen as a client being offered social work services consisting of leadership for four small groups, with the eight PC students and this writer giving the service. It does not stretch the point too far to think of the service being offered to "a family" of about 40 children and parent figures. An adequate evaluation was done in terms of the "sibling" relationship and of the "parental" relationships considering both health and pathology. Following the same model, however, not nearly enough consideration was given to the "parent-child" relationships. As the project progressed, it became clear that emotional neglect directly related to staff shortage and a high level of staff turnover as well as some tendency toward over-protection were operative. This was combined with the fact that the PC students were seen as "outsiders". In fact, there was a strong tendency to see the whole project as something being imposed.

Rather late in the project year, this now obvious point became clear. CHD staff involvement in the project became essential.

As a conceptual point, it seems that an external agency must think of its service as being offered to an institution as opposed to the residents of that institution. This probably has significant implications for clinics, family service agencies, etc. working individually with residents of institutions.

Within the project, two main steps were taken to get at the foregoing difficulty. First, regular conferences were scheduled with the eight PC students, this writer, CHD staff, and the CHD board president to get to know each other, to discuss concerns, to ask questions, etc. As a learning experience, the leadership of these conferences was handled by the PC students. This also gave the staff a glimpse of the students' knowledge and abilities.

Secondly, focus was given to CHD staff responsibility in the learning of the PC students. This was conceptualized and presented in terms of their being co-teachers with the Seminary faculty and this writer. (It is noted that this writer was made a member of the Seminary faculty.)

Operating the Project

The actual mechanics of operating the project were fairly simple. The eight PC students met formally one hour a week with the writer for discussion and instruction related to their CHD experience. In addition, they met one hour a week informally. The work with the children was from 7:00 to 8:00 p.m. on Mondays with a forty-five minute coffee period with this writer to discuss and ventilate about that evening's experience with the children. This period was the single best way to keep tabs on what was still fresh. Conferences were held about every three weeks with the leaders of each group for detailed review. This, combined with lectures by the PC instructor, written and reading assignments and the aforementioned work with

the CHD staff structurally constituted the project. The following modified quotations from students' final summary reports (modified to assure confidentiality) will give the reader a feel for the nature and quality of the experience for the students and the children.

1. Perhaps the most radical change of the nine weeks took place with Larry. When the group was started he was rather reluctant, quiet and reserved. Over Thanksgiving vacation he found out he could go home. Since then he has been enthusiastic and more fully participating in the group than any other member.

Sue, at the beginning was an attitudinal leader but gradually changed until the 12th meeting when she seemed very withdrawn. Last week her interest increased as we planned the picnic.

Louis has been more withdrawn. He went from extreme expression of Harold's type down to very little verbal participation. This participation, however, was generally meaningful in terms of the activities in which we were engaged. We see this decline in activity coinciding with our outside relationship with him as counselors. In his counselor-counsee relationship he is quite open and expressive.

In terms of our own roles, we have both gained a large measure of acceptance and rapport with our group and other kids in the home. We gained a great deal of understanding of the meaning and feeling of being in an institution like the Children's Home. We also gained some insights into how to deal with or work in an administrative organization.

2. It seemed that we were just reaching a point in our group that we could really begin to express feelings without the fear of being hurt by the others. Several stated they could relate much easier how they felt and this must be from a continuous creative process in the group last semester and this.

In the trip to the county home we saw the children's needs being met as well as those of the folks at the home. The youth were in position to love as well as being loved. There was an eagerness to share with others. We were amazed at the manner in which each group was able to transcend the generation between them to create a loving fellowship. From the experience it seems it would be ideal to create a program of service by the youth to the home.

3. The group acts as much more of a unit when they are physically active—as on our hike or some of the other activities. Our discussions with them held their attention only for two or three sessions even when it was something they were interested in, as music. We would advise if this group is carried on next year, that there be more activity and only occasionally some kind of discussion.

Another problematic area in operating

the project centers within the general area of communication. As the reader has perhaps noted, communicating with each other has, in general, been the only really significant rough spot in an otherwise smooth operation. Just as these were operating difficulties in interagency communication, there was some problem in this writer's trying to convey and receive ideas to and from the PC students. At this point, it seems to have reflected a general problem of social workers and ministers communicating with one another. It now appears to be more a matter of words than anything else. It was important to "get the hang of" using such words as; "love," "spirit," "my ministry," "God's work," "honesty" and "happiness." These translate roughly into "social work talk" respectively as; nonjudgmental acceptance, professional dedication, professional objective, enhancing ego functioning, self awareness with professional objectivity, and functionally healthy coping patterns. This is, of course, distorting the fact somewhat but hopefully gets at the problem. As a discipline develops its language, subtle changes in denotation as well as connotative variance occur which tend to make it somewhat foreign to outsiders. Knowing what the dictionary would say does not necessarily result in mutual understanding. This area does, therefore, demand special attention in any interdisciplinary project.

One final operational note should be made. The single most difficult idea to get across to the PC students was that of a non-imposed group structure with the structure growing out of the group via the group process facilitated by good leadership. This concept was meaningless to most of the students, and this writer required about three months to really get the idea communicated. The difficulty seems to reflect the PC students' tendency to think of "con-

trol" in terms of complete control or no control as opposed to more and less control.

Conclusions and Recommendations

1. In communities with limited resources, it is possible to establish new services on an interagency basis by lifting, on a part-time basis, the necessary people out of several agencies and organizing them into a new service unit. This should be based on a documented need for the new service and each agency's willingness to provide support for it. It is noted that the Clinic is attempting to establish a modified "Big Brother" program by pooling its resources with local men's service clubs.

2. At each stage of a project, but especially at its outset, clear and meaningful communication is essential for success. This calls for a well thought out design as solid and as well documented as a research proposal, considerable flexibility and constant focus on the service unit.

3. The implied contract between agencies must be understood and accepted. In addition, it is felt that lifting of personnel from an agency for a project should only be done with their voluntary consent.

4. It is not likely that many communities would just happen to have a theological school, a mental health clinic, and a custodial children's home. The point is, however, that most communities do have some scattered resources which, with a little imagination and a lot of hard work, can be cooperatively modified to develop a new service unit. A few of the typical resources which might be used are; ministers and churches, schools and teachers, men's and women's clubs, health and welfare departments, doctors and nurses, and an eye should always be kept open for a social worker or psychologist who may happen to live in the area.

Ralph G. Hirschowitz, M.B., B.Ch.

Mary Lou Guthrie, R.N.

Marie H. Smith, R.N.

The psychiatric nurse—fox or hedgehog?

Through case histories the authors show the potential inherent in the multiple roles of the psychiatric nurse. Collaborative therapy between nurses and psychiatrist has shown great effectiveness in dealing with troubled adolescents, regressed schizophrenic patients and elderly, depressed patients.

"The fox knows many things,
but the hedgehog knows one big thing"

—Archilochus

In this paper we describe an emergent role for the psychiatric nurse. We do not attempt to discuss what the psychiatric nurse is, but record, instead, our experience of what the psychiatric nurse can *become*. In emphasizing the dimension of becoming, we stress the prescription of *opportunities* rather than the prescription of *roles*. Once a role is prescribed or ascribed, the strong implication is "This is the way it is, and ought to be." In our view "the way it is" is too heavily colored by "the way it was," failing to allow for

At the time this paper was written, the authors were associated with Butler Hospital, Providence, R.I. The senior author, Dr. Hirschowitz, is Research Associate, Laboratory of Community Psychiatry, Harvard Medical School, 58 Fenwood Rd., Boston, Mass. 02115.

growth, for development, or for innovation—all of which are allowed for when opportunities are emphasized. The roles that can then evolve are flexible enough to permit extension, enhancement, and the diffusion described by Jones¹ in his therapeutic community. As recently emphasized by Thompson,² organizational positions require some built-in slack if latent human potential is to be developed and realized.

We further stress, as has Gregg,³ that psychiatry is a generality, not a specialty. The psychiatric nurse not only knows many things, but she is able to do many things. She functions as mothering person, counselor, advisor, friend, teacher, and therapist. She is often the parent surrogate or "maternal auxiliary ego." Patients vary, and so do nurses. The psychiatric nurse responds most effectively who can tailor her response to the patient, his situation, and his need. The effective

psychiatric nurse is multipotential, not unipotential—a fox, not a hedgehog.

Our purpose in this paper is to share our observations, our experience, and our present point of view with our colleagues. In so doing, we realize that we stir up conflict about psychiatric philosophy, ideology, organization, and roles. In our view, a healthy psychiatric system endorses the Socratic proposition that the unexamined (organizational) life is not worth living. Such a system is an open one, responsive to its own error signals and seeking growth-enhancing solutions to its internal conflicts. Self-scrutiny, growth, and change thrive on controversy.

Our collaborative effort began when the senior author (R.G.H.) joined the staff of a small psychiatric hospital where the two nurse-authors (M.L.G. and R.S.) worked. He soon noted that ward staff members were actively therapeutic in meeting the patients' needs. Without formal recognition, aides and nurses dealt effectively with patient crises and provided basic therapy. Also, by the ritualized interaction of the "doctor-nurse game,"⁴ the nurse was making many therapeutic decisions without being *seen* to make them. Through her relationship with the psychiatrist, the nurse was usually able to influence him to prescribe the therapies she thought were indicated. This covert, quasi-manipulative game was challenged by the psychiatrist, who suggested that decision-making could be delegated openly and formally to the nurses. A collaborative contract was established that followed this sequence:

When a new patient was admitted, we spent the first few days attempting to define the patient's problems. Together we observed the behavior of the patient in interaction with his family members and with members of the ward community. Our team would then share observations to

define what the problems were and what might be done about them ("diagnosis and treatment").

During this phase of observation and evaluation, we would note whom the patient tended to approach and the staff nurses who responded most empathically to him. One of these nurses would volunteer to become the patient's therapist. A therapeutic contract would then be negotiated, with the participation and consent of the patient and his family. This therapeutic contract affirmed that therapeutic decisions would be the nurse's responsibility.

A clear consultant contract was established between the nurse and the psychiatrist, providing for scheduled supervision as well as emergency consultation. Decision-making was delegated according to the following paradigm: The nurse was free to make *all* therapeutic decisions about the patient that she felt able and confident to make. If in doubt about a significant decision, she was able to consult the psychiatrist at any time, i.e., 24-hour consultation was available; the only decision the psychiatrist would necessarily have to be seen to make was about medication. (In effect, this decision was made together with the nurse and, sometimes, the patient.) Decisions about "home remedies" were made by the nurse and rubber-stamped by the psychiatrist.

In order to give the reader an opportunity to share the nurse-therapists' experience, descriptions by the two nurse co-authors follow.

Case 1. I had heard and read about nurse-therapists, but had not functioned in this capacity or known anyone who had; so, when I was first asked to assume the responsibility for Mrs. X.'s therapy, my reactions were varied. I struggled with feelings of insecurity and doubt concerning my ability to adapt to this new role. I decided to accept the challenge

in the hope of being helpful to Mrs. X. and increasing my skills as a member of a therapeutic team.

Mrs. X. was a 49-year-old divorced woman. I became her therapist on her third admission. The major factors precipitating Mrs. X.'s admission were a number of losses: the death of her mother and brother, job loss, and the symbolic loss of her three grown children, who were separated by both geographic and emotional distance.

Mrs. X. was admitted to the hospital after having taken an overdose of medicine and having cut her wrists. In this way she had signaled her desperate need for warmth and support, reserves of which had been exhausted during the previous two years. In spite of my feelings of insecurity, I began to work with Mrs. X.

The picture she presented included depression, loss of self-esteem, and guilt. For many years she had functioned under considerable emotional stress while maintaining a pseudo-independent façade. However, the significant losses noted above brought to the surface many dependency needs she could neither acknowledge nor gratify.

The first step in her treatment was to overcome her belief that she had to be "treated" by the psychiatrist in order to receive therapy. In our first few sessions, Mrs. X. struggled with feelings of rejection and anger about receiving help from me, not her formal "doctor." At this time, my therapeutic stance was consistently to hear her out and accept her angry ruminations concerning the "loss" of the doctor. In the process, she was able to ventilate emotions about past real losses, and gradually, if ambivalently, to accept me as a therapist.

Because of the feelings of rejection in the patient and my own feelings of insecurity in the nurse-therapist role, therapeutic progress was often obscured by anxiety. As this diminished, there was increasing acceptance of me, together with the development of trust and the ability to admit and express emergency emotions. As I survived her rages and her testing, Mrs. X. moved closer to me. She then "took flight into health," persuading me to discharge her ten days after her admission.

To ease my own conscience, I was able to rationalize her discharge, trying to convince myself that continued hospitalization would promote regression in her because of her strong dependency needs. (I was to find out later on in my experience that a certain amount of dependency gratification and regression would be necessary in order to improve Mrs. X.'s ability to face the world of reality.) In

spite of my rationalization, my sense of relief was colored by feelings of guilt. I somehow could not really convince myself that discharge was the proper course of action at the time.

A plan for outpatient therapy had been established; but, after two sessions, Mrs. X. was readmitted to the hospital. The picture was somewhat changed, for on this admission she walked into the hospital asking for help openly and without dramatics. Somehow we had established a trusting relationship that enabled Mrs. X. to ask for help in this more appropriate way. Although her discharge had been premature, I did not feel that it was without therapeutic value. The brief exposure to the world of reality seemed to make Mrs. X. more open to therapy.

As therapy continued, I encouraged Mrs. X. to recognize and express the feelings associated with her unresolved grief. My non-judgmental acceptance of her hostility and rage allowed her to accept these feelings in herself without fear of retaliatory punishment or abandonment. Mrs. X. became better able to relax her critical, demanding, punishing conscience and to adopt a more human approach toward herself and her feelings. After several weeks of supportive, non-judging therapy, she resorted less and less to self-destructive tactics.

Because of financial need as well as the need to maintain self-esteem and intact function, we began to plan step by step for Mrs. X.'s return to the community. In view of her great dependency hunger and the absence of helping resources in her family or community, I knew that rehabilitation would have to be a well-planned process. The first step was for Mrs. X. to resume work. To increase her confidence, she was given tasks in the hospital in preparation for a job in the community. When Mrs. X. prepared for job interviews, I encouraged her to express anxiety and fear, to desensitize her for the threatening interview situation.

Mrs. X. was interviewed and hired for a temporary job in a nearby college. As therapy progressed, Mrs. X. was better able to accept and deal with her own limitations. With the stress of change, there was considerable histrionic acting-out of her increased dependency needs. I remained consistent and attempted to foster more appropriate ways for her to deal with her feelings. Her temporary job lasted five weeks. Mrs. X. again experienced the feelings of separation and loss that had been so significant early in her therapy. However, she had progressed to the point where she was able to express and deal with these feelings in a more realistic manner. When her job terminated,

I again encouraged the grief process appropriate to significant loss.

Mrs. X. was able to get a new job within a few days and, at the time of this report, was functioning in that position. She will continue to receive supportive treatment. In a few weeks, we will deal with plans to move from the hospital into the community. Continuity of therapy is planned until she is completely rehabilitated.—M.L.G.

Case 2. Mrs. A. had been hospitalized for approximately three weeks when I became interested in her therapy. This was her fourth admission to a psychiatric hospital, and on this admission she was five months pregnant. She had been transferred from a general hospital where she had been hospitalized for a respiratory infection.

Mrs. A.'s behavior was chaotic and bizarre when I first started to help her. She was actively hallucinating and exhibited delusional thinking. She would isolate herself in her room and rock endlessly, sitting on the side of the bed. When she became frightened and agitated, she would try to bang her head on the wall or scratch or cut herself.

Mrs. A. had worked in an insurance company office. She had recently married a man she had met while hospitalized at the state hospital. He had been married previously, but had no children. Mrs. A. became pregnant at a time when the marriage was very unstable. Her husband did not accept her pregnancy and wanted Mrs. A. to "give up" the baby when she delivered. He was abusive and combative with her when she was at home.

My first objective in becoming Mrs. A.'s therapist was to establish a relationship of trust. My conversations with her were reality oriented and took place in her room. Much non-verbal communication took place during the first week, and I found I could reassure Mrs. A. and prevent her from harming herself simply by putting my arm around her shoulders.

I consulted frequently with the psychiatrist. We decided to increase the patient's psychotropic medication to eliminate the "noise" that plagued her continuously. This led to the first test of her trust in me. We talked about what the medicine meant to her. She expressed her fears hesitantly at first, then verbalized freely—she feared her husband would now have proof that she was "mental" and could then have the baby taken away from her.

This led into a discussion of how frightened she was of her husband. It was at this point that I

decided to restrict her husband's visits. When I told Mrs. A. this, her relief was quite apparent. She took her medicine and slept soundly for the first night since her admission. The next day I gave Mrs. A. the responsibility of taking the supplementary vitamins prescribed for her pregnancy. This helped reinforce trust and confidence.

Soon Mrs. A. became more lucid and, in our daily, hourly sessions started asking questions about pregnancy, delivery, and caring for a newborn baby. I was then able to deal with fantasied as well as realistic fears, giving her "anticipatory guidance" as described by Caplan.⁵

Mrs. A. did not discuss returning to her husband. I consulted the psychiatrist, and we thought that a family meeting to explore possible marital therapy was now indicated. Mrs. A. went along with this reluctantly. I called Mr. A., and he agreed to come in. (He had not seen his wife since I had restricted his visits. He had called daily for information and had tried several times to invade the ward to visit his wife. His attempts to see her frightened Mrs. A., but she trusted me more when she knew that I could control him, and she felt she could depend on me to protect her.)

In the days preceding our family meeting, Mrs. A. discussed her relationship with her husband. Although ambivalent, she decided that she wanted a separation. Since she was feeling and thinking clearly, I did not try to influence her decision. I did reassure her that the psychiatrist and I would support her in whatever she decided.

At our meeting, Mrs. A. announced to her husband that she wanted to leave him. She explained to him that she was frightened to be alone with him since he had hurt her many times. Mr. A. denied this and expressed some paranoid ideas, accusing the doctor and me of conspiring against him. We suggested another meeting to give him an opportunity to seek help himself and to have someone along to help him represent his interests. (Mr. A. did not keep this later appointment.)

After this, Mrs. A. requested that she be taken off medicines. We discussed this, and I tried to get her to express her feelings about the medication. She felt that it meant she was still sick and dependent. I doubted that discontinuance was wise, but decided to try it. That afternoon, Mrs. A. admitted that she had not taken her medicine anyway for the previous three days. This had convinced her that she would not need it any more.

That evening, Mrs. A. displayed evidence of regression; she exhibited disorganized, psychotic behavior similar to that of her first few weeks in

the hospital. Realizing that she was unable at that time to make responsible decisions for herself, I put her back on her previous medication. In several days she was markedly improved.

So that continuity of treatment might be assured across shifts, Mrs. A. received considerable supportive therapy from Mrs. F., an aide on the evening staff. This was extremely important since the evenings were long and frightening for Mrs. A. Mrs. F. and I met daily for 20 minutes to discuss Mrs. A.'s behavior and share objectives regarding her care. Our tactics stressed reality and supportive reassurance.

Mrs. A. expressed a desire to work and keep busy. I arranged a work program in which she was a "pan"• on the geriatric unit. She enjoyed helping others and handled the responsibility and independence well.

It was now time to initiate discharge plans. Mrs. A. was on government aid before her admission, and was followed by Mental Hygiene, a community agency. I contacted Mrs. P., the social worker responsible for Mrs. A. It was not too late to renew Mrs. A.'s application for aid. Mrs. A. and I met twice a week with Mrs. P. to work out financial matters.

I met with her two aunts (her only family), and we shared Mrs. A.'s plans to leave her husband. They agreed to visit Mrs. A. and do all they could to support her in her decision.

Mrs. A. found a suitable apartment and was discharged with plans of being followed formally by Mental Hygiene, but with the right to call on the psychiatrist and me at any time for help. Also, we remained available to her social worker as consultants.

Two days after discharge, Mrs. A. fell and fractured her right leg in four places. She was hospitalized in a general hospital, and a cast was applied. She had numerous complications, including hypostatic pneumonia. She weathered this crisis without becoming psychotic.

Several weeks after her discharge from the general hospital, she went into labor and was readmitted. She delivered a baby boy. Since she still had the cast on her leg, her obstetrician thought it best she go home without the baby. At this point Mrs. A. became panicky. The obstetrician called for a psychiatric consultation, and it was decided

that it would be more harmful if Mrs. A. went home without her baby.

Mrs. A. was discharged with her baby, and her aunt stayed with her for several weeks. Her cast was removed, and she was able to manage by herself.

She called me and told me about her complications after discharge, but said she was doing well. I visited her and found her quite content.

Mrs. A. has obtained a legal separation, and is no longer frightened of her husband. She refers to her baby as a "miracle baby" and is extremely proud of him. She seems quite capable of caring for him and continues to be doing well.

The role of nurse-therapist was an extremely rewarding one for me. Despite my initial anxieties, Mrs. A.'s progress and responses in our relationship proved to me that I had been an adequate therapist.—R. S.

Many other rewarding, collaborative experiences with nurses occurred. In one case, the psychiatrist, together with a nurse, formed a therapeutic team to help a patient diagnosed as hebephrenic schizophrenic.

Case 3. This patient, aged 21, had been intermittently psychotic since the death of her mother some four years previously. An only child, she had lacked the internal ego resources as well as external supports to cope with separation and mourning. (Her father was an ambulatory schizophrenic quite unable to deal with any stressful events.) The dead mother had often punished the patient with such threats as "You'll be the death of me" or "When I die, you'll be sorry." Under these circumstances, the patient had totally denied the reality of her mother's death and had held on to the mother by incorporating her. In speech, dress, and mannerisms she had become her mother. In addition, she appeared to be paying the expiatory price of relieving the mother's illness and developing her symptoms. (The mother had died of a ruptured intracranial aneurysm.) The patient, in panic, would often develop symptoms of headache or rushing noises in the head, which she experienced as bleeding and dying. She was often cold, and felt and looked like a corpse. At these times she would report in terror, like Laing's patients,⁶ that she was "petrified," "in hell," or dead. It was often necessary to touch and hold her to affirm for her that she was alive.

* Following Maxwell Jones we inaugurated a work program for "pot" and "pans." A P.O.T. is a Patient Occupational Therapist and a P.A.N. is a Patient Assistant Nurse.

In order for this patient to relinquish her hold on the dead mother and find it safe enough to return to the world of real objects, it was necessary for the therapists to extend themselves to her so that she could develop absolute confidence that her needs for warmth and anaclitic support would be consistently met. The psychiatrist and nurse-therapist spent an hour or two with her daily. Together we shared our empathic responses to her needs. Early in therapy, many of our interventions were intuitive and symbolic, in ways that have been described by authors like Schwing⁷ and Sechehaye.^{8,9} The patient would often need to be held, comforted, and rocked when overwhelmed by separation anxiety, emergency emotions, and weird, uncanny sensations. The nurse-therapist was able to hold and touch her without threat. It took some time before the patient would accept that the psychiatrist could be trusted to help and not harm, hurt, use, or abuse her. (There was considerable evidence that incestuous behavior between father and daughter had contributed to her marked ambivalence toward males.)

The patient's great terror and rage were often communicated by contagion to the therapists. As co-therapists we were able to support one another as we attempted to unravel together her symbolic communications. After many weeks of intensive co-therapeutic effort, the patient symbolically buried her mother and was able to reconstruct and work through those traumatic life experiences that, in psychosis, she was re-experiencing and re-enacting in fragmented hallucinations, as well as dissociated thoughts and emotions. A therapeutic effort that had begun as supportive, anaclitic therapy gradually became more intensive and reality-focused.

As the patient progressed, the nurse-therapist left the hospital. The patient was adequately prepared for this, and was able to work through this separation without becoming psychotic. The patient remained in therapy with the psychiatrist. She survived the first anniversary of the symbolic "burial" of her mother. This involved remembrance and stormy re-mourning. Although she re-experienced some of her mother's symptoms, she was able to label her emotions appropriately and had insight into what was occurring.

This patient has not needed to resort to psychotic solutions to continuing life problems. In reconstructing the course of her successful therapy, we are satisfied that she would not have reached her present adaptive level had a nurse-therapist not been initially involved.

Other nurse-therapists have been able to show that "The fox knows many things." The nurse-therapists have functioned successfully with troubled adolescents, with regressed schizophrenic patients, with relatively robust patients temporarily overwhelmed by situational crises, and with elderly, depressed patients. Nurse-therapists have been conspicuously effective as marital therapists, as family therapists, and as group therapists. As a result of collaborative therapy, many patients, some families, many nurse-therapists, and one psychiatrist have all experienced significant growth and learning. We have been able to learn together, grow together, and work together in a context of ever-enlarging mutual support and respect. We think we have demonstrated that the nurse knows many things and can do many things if given the opportunity.

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Psychiatric social clubs come of age¹

In the last 20 years a substantial body of experience and thought has accumulated that favors more comprehensive and effective community intervention in the treatment, care, rehabilitation, and prevention of mental illness. The final report of the Joint Commission on Mental Illness and Health,¹ in 1961, and its emphasis on action led to the Community Mental Health Centers Act of Congress in 1963, which dealt first with the construction of facilities and, later, as amended in 1965, with the staffing of such facilities. Among the services spelled out for these centers were two that are relevant here, namely, rehabilitation and aftercare services. As stated in the Joint Commission report, "the object of aftercare or rehabilitation programs for mental patients is, insofar as possible, to enable them to maintain themselves in the community after they leave the hospitals."

By aftercare was meant such facilities in the community as halfway houses, rehabilitation centers, ex-patient clubs, foster care programs, and clinics available to discharged mental patients. These programs were considered helpful in dealing with three general problems encountered in the

rehabilitation of ex-patients: (1) tailoring care to their needs, (2) grading stress, and (3) providing continuity of care.

Of all the aftercare programs, the ex-patient clubs are probably least known and understood.

Rationale and History of Social Clubs

Dr. Joshua Bierer started the first therapeutic social club, as we know it, in Great Britain shortly after he arrived there from Vienna in 1938.² The club was initially within the hospital setting; later, it was in the community. In America a somewhat related trend took place in the founding of Alcoholics Anonymous, in 1935, and the somewhat less well-known Recovery, Inc., in 1937. However, these latter two movements tend to offer a ritualized and limited form of group therapy compared with the more informal, broadly based, socialization activities characteristic of the social club.

Early in the 1930s, the famous American psychiatrist Harry Stack Sullivan,³ working intensively with schizophrenic patients, concluded that "The path to social recovery seems to be along the line of really sympathetic environment. . . . Given the correct situation, the 'social' recovery goes far towards a 'real' recovery and certainly includes much of a true reorganization of the disordered personality." He described the interpersonal situation in which such social

Dr. Grob is executive director of the Center House Foundation, which operates the Center Club, 48 Boylston St., Boston, Mass. 02116.

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recovery could take place as "one of education, broadly conceived, not by verbal teaching but by communal experience—good tutoring." Of interest to us is his remarkable foresight in expecting an increase in the relapse rate unless there was developed what he called "convalescent camps and communities for those on their way to mental health."

Fountain House,⁴ the first psychiatric rehabilitation clubhouse in the United States, had its origin, after the Second World War, in meetings of a small group of patients (from Rockland State Hospital) that went under the name of WANA—We Are Not Alone. This group, which met on the steps of the New York Public Library, was provided with a meeting place of its own when interested citizens purchased a building to house its activities. From this small beginning in 1948 Fountain House evolved into a large social rehabilitation center serving the New York metropolitan area. It is interesting to note that its first executive director was Sara Boddinhouse, a psychiatric social worker who had had considerable experience with therapeutic social clubs in London.

Still more interesting, Miss Boddinhouse later became executive director of the San Francisco Fellowship Club when it was established as a two-year demonstration project, in 1956, under the sponsorship of the San Francisco Association for Mental Health. In contrast to Fountain House, this group selected a community center for the club's meeting place, following the philosophy that the psychiatrically handicapped should not be isolated in their recreation and socializing activity in a facility solely for their own use. Any expansion of the club was viewed in terms of encouraging development of club groups in various community centers rather than of establishing a separate building for the pro-

gram. This model was closer to the English system.

At this time, only 12 years ago, it was estimated that there were only ten such social clubs for psychiatric patients in the entire United States. By 1959, three years later, it was estimated that there were about 70 ex-patient clubs in the country, the largest concentration of them being in California. Recovery, Inc., claimed 250 groups in 20 states. Though the exact number in existence today is not known, there is no doubt (on the basis of the experience of Massachusetts and Connecticut alone) that the number has multiplied even more. The persistence and growth of social clubs in the face of great difficulties in financing, staffing, and management speak eloquently of their inherent value for mental patients returning to community life.

In the last ten years, an increasing number of research reports and articles have appeared, in various journals and books, that evaluate the experience of Fountain House, Horizon House, the Center Club, Hill House, and others. The findings, though not conclusive, have certainly been favorable and have indicated that the clubs are a move in the right direction. The general trend in program development common to these clubs is to incorporate, within a broad pattern of socialization, such elements as prevocational training, job counseling, group therapy, personal adjustment counseling, and housing services in addition to consultative, educational, referral, informational, training, and research functions.

This growth has been accompanied by a corresponding growth in diversified staff, volunteer participation, and member roles in the operation of the club. Psychiatrists and families of ex-patients have increasingly come to regard these programs as valuable adjuncts to psychotherapy or drug therapy, especially for the resocialization and remo-

tivation of chronically disturbed persons with a long or recurrent history of illness. In 1963, under the sponsorship of the National Association for Mental Health, Inc., a broad representation of practitioners and social scientists met in a consultation on social clubs and gave unequivocal endorsement and support to such clubs. In surveying their chapter members in preparation for this consultation, the NAMH found 59 social clubs, the majority of them meeting one or two nights a week.

Varieties of Clubs

Though no two clubs are exactly alike, and may even pride themselves on their differences, they show basic similarities in origin, purpose, and program development. They derive from the same *gemeinschaft*, the idea of the therapeutic community (called a third psychiatric revolution by some), initiated by Bierer and Jones in England. Elements of the therapeutic community ideas had appeared earlier in history; but, like so many ideas, they were revived in a new form and context corresponding to contemporary needs.

Mr. W. Tuke, an English Quaker layman disenchanted with the medical treatment of the insane, founded, in 1796, what was called "The Retreat" (to avoid the stigma associated with the common terms "asylum" and "madhouse"). Among his objectives were: (1) provision of a "family" environment for the patients, manifested in the non-institutional aspect of the building and its surroundings; (2) emphasis on employment and exercise as being conducive to mental health; (3) treatment of patients as guests rather than as inmates. This practice spread to America in the early nineteenth century and became known as moral treatment.

Without the ideas and experiences inspired by the concept of the therapeutic

community, ideas that were first applied to the mental hospital, it is doubtful that social clubs would have gained the attention they now enjoy. However, as clubs have evolved in different cities and towns, they have taken on the idiosyncratic coloring of the special environment, locale, history, leadership, and culture within which they are embedded. As a result, they tend to develop, each in its own way, a unique patterning of ideology and performance appropriate to their separate needs.

Fountain House,⁴ in New York City, is today a far cry from WANA. It is the largest social rehabilitation center in the country, serving an estimated membership of about a thousand persons. It has a total capital and operating budget of \$2 million. Functioning in a large building of its own, with a staff of about 40 full-time professionals aided by many volunteers, it offers a comprehensive rehabilitation service comprising day, evening, and weekend social and recreational programs, transitional employment with counseling and placement, a far-flung apartment program, and many educational, training, consultative, and research activities.

Horizon House,⁵ in Philadelphia, was started in 1953 by a young woman who had been a mental patient herself and who, inspired by Fountain House, organized other former patients into a group. Meeting one night a week in a church room, the group graduated in 1956 to a two-room apartment and, in 1959, to a building of its own. The combination of services offered to Horizon House's 700 members today, made possible by a budget of over \$1 million a year and a professional staff of about 30 aided by 30 volunteers, includes the House itself, which serves as social and recreational center, a vocational program of sheltered workshops, job guidance and placement, personal counseling,

and psychiatric consultation. Although Fountain House elects to place members in apartments and transitional jobs in the community, Horizon House prefers to have its own halfway house for men nearby and three sheltered workshops.

The Magnolia Club was started by the Louisiana Association for Mental Health in 1956-57 as a weekly group meeting primarily for socialization.⁶ Experience gained from this club has been summarized in an excellent monograph, by Mabel Palmer,⁷ that deals with the technical aspects of developing a social club.

Council House,⁸ in Pittsburgh, Pa., was founded in 1957 by the Pittsburgh section of the National Council of Jewish Women, a voluntary service organization of citizens known for their social service interests. At its height (aided by an NIMH grant from 1962 to 1964), Council House served 300 ex-patients a year. A small professional staff and budget were maximized by the use of other agencies and settings for programs and activities.

Thresholds, Inc., in Chicago, was also founded by a local section of the National Council of Jewish Women, in 1961. Though it has experienced financial difficulties over the years, largely because of the narrow base of community support, it has persevered and is presently following the Fountain House model rather than that of its sister organization in Pittsburgh.

The first social club in Massachusetts was known as the 103 Club because of its address right outside the Boston Psychopathic Hospital, now the Massachusetts Mental Health Center. This club grew out of a patient government program started in 1948. Discharged patients were encouraged to meet weekly at club quarters under their own indigenous leadership, with the help of volunteers and occasional access to hospital staff across the street. Though not

purely self-governing because of its proximity to the hospital, it enjoyed a surprisingly long life so long as it had charismatic leadership to keep it going. When this failed, the club began to disintegrate.

In the meantime, early in 1958 a small group of ex-patients were meeting weekly with me to discuss problems of living after leaving the hospital. The idea of a club was born without any knowledge of the 103 Club, as these ex-patients came from other hospitals. One of the group obtained quarters in a nearby church for weekly meetings. With professional and volunteer help from the outset, this group increased rapidly in size until over 100 people were attending weekly meetings, which imposed a strain on the limited facilities of the church. Subsequently, the club moved to rented quarters in a friendly "Y" where, under the stimulus of a federal grant from the Vocational Rehabilitation Administration and continued sponsorship of the Massachusetts Association for Mental Health, Inc., it grew to a full-time enterprise.

At the suggestion of the hospital administration, the old 103 Club was merged with Center Club, and contributed much to its early leadership and enthusiasm.

The club, now entering its tenth year, has a Board of its own, the Center House Foundation, and has a budget of close to \$75,000. A staff consisting of professionals, pre-professionals, non-professionals, and volunteers operates a program of varied activities 75 hours a week for over 300 members. Since the expiration of the federal grant in December 1964, the club has been supported entirely by voluntary contributions from foundations, friends, and the Massachusetts Association for Mental Health, Inc.

Recently we have signed contracts with the Boston State Hospital on the basis of

which we will receive fees for services rendered their discharged patients up to an annual maximum of \$25,000. We have just received a federal staffing grant through the Tufts Mental Health Center, for whose patients we will be providing rehabilitation services for the first time. In addition, we have a limited agreement with the Massachusetts Rehabilitation Commission that allows us fees for serving any of their workshop clients who come to the Center Club. As a result of this federal-state aid, now forthcoming at long last, our Board and staff can look forward to more hopeful prospects of continued development and expansion of services for all discharged mental patients coming to the Center Club's attention.

Since I have been identified with the Center Club and the Center House Foundation from the beginning, and since it has gone through so many of the experiences of the other programs to which we have referred, I think it permissible to use this experience in discussing some basic questions every community must ask about a social club for ex-mental patients.

Major Issues

1. *What is a social club?*

Common elements of a social club are (a) that it be community based, (b) that it be non-institutional, (c) that it be intrinsically social, (d) that it be democratic in emphasis, (e) that it exhibit a preference for horizontal ordering of staff and volunteer roles, and (f) that it concentrate on group activity, the principal vehicle of rehabilitation.

We view the club as a voluntary community rehabilitation center for seriously handicapped ex-mental patients who are there offered opportunities to plan and carry out, with staff guidance and volunteer help, a varied program of social, recreational, edu-

cational, cultural, and vocational activities. The primary goal is to create a social and cultural environment that will help to motivate and activate discharged mental patients to return to normal community life and useful employment.

The focus of staff attention is on the utilization of all club activity for reality orientation and ego strengthening. Emphasis is placed on present and future prospects. Learning by doing things together, daily or weekly throughout the year, is the means employed to advance the process of rehabilitation.

2. *Why is there a need for social clubs?*

It is necessary to understand that clubs address themselves primarily to people who have suffered from a social breakdown, usually requiring hospitalization. It is this group that has contributed most to the high readmission rate of recent years, estimated at 40 to 50 per cent (larger than formerly because of the more liberal discharge policies attendant upon the use of pharmacological therapy).

Though it is advantageous for clubs to encourage participation by a heterogeneous population of personality types, the major problem is the chronic, long-term patient returning to the community. Coleman⁹ says of these patients:

If they can be characterized in any way, one may think of them as people who are more vulnerable than others, more easily hurt, less resilient in the face of stress and rejection . . . with a long history of severe characterological problems . . . suffering from a chronic, ingrained disturbance. There are many such people in communities, and they do not all become patients in mental hospitals. Their relation to others is often tenuous, lacking in closeness, and peripheral. Often, too, they are socially isolated, particularly in terms of their own feelings, and need an acceptance which does not impose pressures or demands for emotional response. By and large, these are the most neglected patients in our society, not only because it is so difficult for them to make known their distress, but also because,

made known, it is so often likely to arouse little response of sympathy or concern.

The club approach is particularly suited to helping this type of person. Always open and available, staffed with varied, friendly, interested, resourceful people, oriented to concrete events and activities taking place in the present and immediate future, the club ultimately becomes a source of hope, encouragement, and strength derived from shared suffering and mutual aid. The social club is a valuable ally of clinical psychiatry in providing a base that anchors the individual's ego to reality and continually educates him to the practical use of better adaptive techniques.

A full-time club program throughout the week, with special provision for evening and weekend activity, extends the safeguards immeasurably and counteracts many regressive tendencies at crucial times. Initiative-stimulating group and individual activities encouraged in the club, whether in the form of parties, meals, discussions, sports, etc., tend to normalize and stabilize the behavior of members and lead to the more normal patterns of thought and feeling necessary for improved social and vocational functioning in the wider community.

3. How does the club fit into the pattern of comprehensive community mental health planning?

Dr. Robert H. Barnes,¹⁰ executive director of the Greater Kansas City Mental Health Foundation, recently stated that the future of the community mental health center movement is going to rise or fall on its ability to deal with the long-term patient: "I would suggest that we think in terms of rehabilitative goals, aiming for social and economic restitution as much as possible. This should include active participation by the patient and persons in his immediate environment, hopefully his family. . . ."

Some studies of the Fort Logan Mental Health Center have shown that discharged, long-stay patients tend to accumulate on outpatient services and impose a strain on the limited time of the available staff.¹¹ The social club serves to ease this burden on limited medical and psychiatric personnel by providing the kind of supportive help that tends to reduce symptoms and prevent relapses or threat of relapses. It serves, in effect, as an ombudsman for the ex-patient, representing him with other community health, welfare, social, and rehabilitation services whose help he may require. It offers a practical way of linking the fragmented efforts of different agencies, facilitating a sharper focus on relevant problems and an integration of appropriate services.

For these reasons, it is not surprising that the club is emerging as an essential component of every community mental health center in the country. What veterans gain from their service representatives in veterans organizations, union workers from counselors in their labor organizations, industry from their representatives in the Chamber of Commerce or National Association of Manufacturers, ex-patients will gain from their representative organization and reference group, the social club. It is becoming a vital link in the continuum of care from the hospital to the community, centrally located in the complex network of helping agencies.

4. Where are clubs best located and housed?

Clubs today may be found almost anywhere: in churches, YMCAs or YWCAs, community centers, settlement houses, mental health centers, or buildings of their own. They are generally located in areas where large populations are centered and varied resources are available.

Three trends are discernible:

1. The purchase of a separate building

or house exclusively for the use of the club, e.g., Fountain House, Horizon House, Threshold, Inc., and Hill House. This type of setting tends to lose its identity as a club and becomes more agency-like in structure and function.

2. Use of space in existing facilities hospitable to the idea, such as churches, YWCAs or YMCAs, community centers, settlement houses, and the like. This retains the small-club character and seems less likely to isolate the program from the community. It has the advantage of encouraging easier access because of the accepted status of the host setting in the community. Opportunity for interaction with other groups in the host setting provides experience in relating to the wider community. Examples of this trend are Recovery, Inc., the San Francisco Fellowship Club, the Magnolia Club, and most clubs presently sponsored by the Mental Health Association. These clubs follow the English model, usually meeting one evening a week.

3. The third type combines the advantages of a full-time program like the first but is located in a host setting like the second, preserving both professional guidance and self-government. Council House and the Center Club are examples of this arrangement. This type of club strives to maximize the functional value of a club within a larger framework of social and vocational activities.

Our experience suggests that the club model per se, large or small, has some advantages over the house. It provides an object of group identification and a laboratory for experimenting with many new expressive, instrumental, and social skills evoked in the voluntary, informal, self-governing climate of the club. In addition, this model utilizes existing facilities available at low cost, saving the community capital funds that would be necessary for construction and maintenance of entirely separate facili-

ties. This approach is attractive because of its relative economy and effectiveness of design. It is likely to spread more rapidly because of its reproducibility.

5. Who can best organize and operate the program?

The major problem of most clubs initially is the degree of professional guidance or direction considered desirable. The clubs run the gamut from the one extreme of purely self-help organizations, such as the American Conference of Therapeutic Self-Help Clubs, Alcoholics Anonymous, and Recovery, Inc., to mixed types in the middle like the Fellowship Club, Council House, and Center Club, to the other end of the continuum, large social rehabilitation centers such as Fountain House and Horizon House. It is possible that these differences in pattern of organization reflect different levels of experience, membership needs, and program development in relation to the community served as well as different concepts of leadership and aftercare philosophy.

In our club we have succeeded in maintaining partial self-government through a council, with annually elected officers, that functions explicitly with professional guidance and consultation. We have recently carried this a step further and now have a responsible member of the club serving on the Board of Trustees in an ex officio capacity.

Obviously, the degree of self-government permitted in a club is related to its constituency and purpose. It would seem desirable to utilize the self-governing impulse, which appears perennially in history, and which has cradled so many useful movements and clubs in this country. It is necessary, however, to use this mechanism within a framework of professional guidance and

consultation. It is on the quality of such guidance and consultation that the effectiveness of self-government will, in the long run, depend.

Few professionals from any of the disciplines have the training or ability as yet to fulfill the requirements. They will have to be selected and trained anew if they are to function effectively in this new role.

Almost all the clubs to which we have made reference are run under voluntary auspices with varying degrees of federal-state aid, either through grants or contracts for services on a fee basis. Voluntary contributions are generated by Boards, which solicit funds from foundations, friends, and interested individuals. Auxiliary groups assist with special fund-raising events or projects; members (clients) and their families may pay dues or share the expense of some event or activity in which they participate.

Since so many ex-patients have been, and often continue to be, recipients of state aid, either as patients in state hospitals or welfare recipients, it is a refreshing change for them to be voluntary members of private, non-profit, self-help organizations oriented to values of self-reliance, independence, and productivity. In addition to these advantages of voluntary character, such groups find more latitude for experimentation in programming, staffing, and financing, i.e., they have more innovative potential than would be likely under state control, with its inevitable bureaucracy, red tape, and political involvement. Mental Health Associations or Boards emerge as intermediaries between the concerned public and the community to represent the needs of social clubs and the relative responsibilities of the community and the state.

It will remain for future research to evaluate fully the effectiveness of social clubs in the area of aftercare and rehabilita-

tion. The social-vocational model exemplified in the social club emphasizes social training and rehabilitation in order to overcome social and vocational handicaps and prepare ex-patients to cope with the requirements of daily living. This is quite different from the medical model, which focuses on psychopathology and treatment in the medical tradition. To achieve its goals, the social club evolves a structure more akin to the old neighborhood settlement house, rooted in community needs and oriented to action on a co-operative basis on behalf of mental health values and needs.

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Armin Loeb, Ph.D.

Kenneth Orkin, M.S.

Andrea Oldakowski, M.Ed.

Three methods of contacting employers to obtain jobs for the rehabilitated psychiatric patient

A continual problem faced by vocational rehabilitation and placement counselors is finding suitable jobs for psychiatric rehabilitees. Most sheltered workshops and work adjustment programs include staff members specifically concerned with discovering employers who will hire ex-mental patients. The salesmanship involved is often difficult, time-consuming, and, sometimes, discouraging. Usually, the rehabilitator uses a variety of techniques in attempting to persuade employers, but the efficacy of different approaches has not previously been systematically studied.

The purpose of the present experiment

was to establish the relative effectiveness of three methods of initial employer contact, letter, telephone call, and personal visit, in obtaining job orders or expressions of interest in hiring qualified graduates from the vocational programs of a psychiatric rehabilitation center. The letter approach was used because it was potentially the most economical; the other two approaches were employed because of the possibility that the "personal touch" might prove more successful. The rationale for including two kinds of personal contact (phone call and personal visit) was derived from a previous experiment, in a somewhat different context, that had indicated that the less expensive telephone method was just as effective as a personal visit in achieving the desired outcome.¹ Another aspect of the experiment was to compare the response rates of large and small business firms to these different forms of contact.

Dr. Loeb is research director and Miss Oldakowski is a vocational counselor at Horizon House, 1823 Pine Street, Philadelphia, Pa. 19103. Mr. Orkin is co-ordinator of the Aftercare Rehabilitation Service at Hahnemann Community Mental Health Center, 314 North Broad Street, Philadelphia, Pa. 19107.

Method

Subjects

Subjects were randomly selected from 2,400 major business establishments in Greater Philadelphia listed in a directory published by the Chamber of Commerce. One-half of the subjects were chosen from businesses with 1 to 99 employees, and one-half from businesses with 100 or more employees. The distribution of subjects according to the three experimental conditions was as follows: letter—105; phone call—49; personal visit—27. There were 105 control subjects who were not contacted at all—to ascertain whether job orders would be submitted without any special contact. Prior to this study, none of the businesses in either the experimental or the control group had ever notified the psychiatric rehabilitation center of any job openings.

Procedure

For all companies, the contact was made with the personnel director, if there was one; otherwise, the vice-president or president was contacted. The same vocational counselor made all phone calls and personal visits and signed all letters. The contacts were made in a five-week period. The content of the message was kept as similar as possible in all three approaches.

For the first group, a letter was sent briefly explaining the vocational services of the rehabilitation agency and requesting the employer to return an enclosed Interest Form. On this form the employer was asked to check one of these three alternatives: (1) there were job openings available (blanks for listing the specific job orders were included); (2) there were no openings at the time, but the firm would be interested in interviewing qualified applicants as future job openings arose; (3) the firm was not interested in interviewing qualified applicants from the agency.

In the second approach a similar message was relayed on the phone, and the person was told that he would receive a letter (the same as in the letter approach), including an Interest Form, which he was requested to return.

In the third approach, the counselor went to see the person in charge of hiring and delivered the same basic message. Again, the contacted person was told that a letter and Interest Form would follow and was urged to return the form.

The response to the first contact was so low—only 7 per cent of all Interest Forms were returned—that a second letter was sent to those subjects, in all three experimental groups, who had not responded to the first contact. This letter, mailed

about two months after the start of the experiment, included a copy of the initial letter and another Interest Form, and emphasized the importance to the rehabilitation center of receiving a response. This second letter produced replies from an additional 24 per cent of the business firms. The follow-up period for the second letter was one month.

Results

The primary dependent measure in this experiment was the number of job orders received. Also of importance was the frequency with which companies indicated they were interested in future applicants and the number of employers who indicated they were not interested. In addition, these measures were compared to determine whether there were response differences as a function of the size of the companies (small, under 100 employees, or large, 100 or more employees).

The major findings are presented in the table below. There were no significant chi squares for any comparisons in this table. Thus, it can be seen that the total frequency of response was about the same for the three approaches. The percentage of job orders received was also relatively constant. Furthermore, the percentage of employers indicating they were interested or not interested did not differ significantly for the three groups. The table also shows that large and small companies responded fairly similarly, although there was a tendency for more small companies to state that they were not interested. None of the firms in the control group notified the agency about any job openings.

Job orders submitted by the eight companies (some of the orders were for several positions) included requests for clerical and office help, salesmen, kitchen help, weavers, and machine operators. The counselor felt that the employers were generally receptive and cordial, though sometimes confused about the goals and problems of vocational rehabilitation. Some respondents who in-

Frequency and percentage of responses for three types of employer contact

	<i>Job orders</i>		<i>Interested</i>		<i>Not interested</i>		<i>Total</i>	
	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>
Letter (N=105)	4	4	14	13	14	13	32	30
Phone (N= 49)	3	6	8	16	3	6	14	29
Personal visit (N= 27)	1	4	4	15	5	19	10	37
Total (N=181)	8	4	26	14	22	12	56	31

	<i>Small companies (N=92)</i>		<i>Large companies (N=89)</i>	
	<i>Number</i>	<i>Per cent</i>	<i>Number</i>	<i>Per cent</i>
Job orders	3	3	5	6
Interested	13	14	13	15
Not interested	15	16	7	8
Total	31	34	25	28

licated they were not interested nevertheless expressed their best wishes.

All job orders and expressions of employer interest were turned over to the vocational department for active follow-up.

Discussion

This experiment clearly indicated that, at least with regard to the initial employer contact, a considerable saving in time and money can be effected by letter rather than personal contacts. The study also dramatically emphasized the effectiveness of a follow-up reminder in significantly increasing the total percentage of responses. As indicated in a previous experiment as well,² a phone call appears to be as effective as the more costly personal visit. It is also noteworthy that there was apparently little difference in response as a function of the size of the business.

The relative paucity of immediate job orders that were obtained was rather disappointing even though it was better than the zero response for the controls. Also, it

remains to be seen what happens with those employers who only expressed an interest. Moreover, it was not too encouraging that more than two-thirds of those contacted did not respond at all. Possibly more active follow-up of the non-respondents could alter this situation.

This investigation demonstrates that small-scale, inexpensive, but carefully controlled experiments can be used to help solve the numerous problems involved in psychiatric rehabilitation, such as opening up job opportunities. Furthermore, it immediately suggests subjects for other possible experiments—e.g., systematically varying the content of the letter, or varying the length, frequency, and content of personal contacts.

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Using an education model in a sheltered workshop program

Over the century-old doorway to the administration building at Jacksonville (Illinois) State Hospital, a new inscription has been affixed. When the doors of this venerable structure opened to admit patients in 1852, it was the first "insane asylum" in the state. Now, with acknowledgment to Harry Stack Sullivan, the new slogan over the doorway reads, in gilt lettering: "MENTAL HOSPITALS SHOULD BE SCHOOLS FOR LIVING."

How do we apply school concepts to hospital programming? One of the ways is illustrated by a special program now being developed as part of the Jacksonville Hospital's sheltered workshop system.

The objectives of this program are two well-known ideals in rehabilitation work with mental patients: (1) to have the patient wish to choose a field of work, and (2) to get him to obtain a job in his chosen field. Various alternative ideals and goals can be cited; but, as objectives, getting the

mental hospital patient to make a job decision and to make an effective job application are often desirable, but difficult of attainment. To get a job for a patient is a common goal, a common practice, and a practical and commendable procedure—but note that it is different from the objectives under consideration here, which are more subtle and profound in their psychologic demand on the patient since they encompass volition, decision, and adequacy in stressful interpersonal contact.

In the plan of the sheltered workshop program at Jacksonville State Hospital, the special program for "teaching" patients capability in choosing a job and applying for a job is derived from educational methods used in our school systems. The principles of educational psychology invoked can be elucidated by describing the experiences of a patient proceeding through the planned system.

First application: volition and minimum essentials. To obtain a job in the workshop, an interested and eligible patient

Mr. Safer is rehabilitation supervisor at Jacksonville State Hospital, 1201 South Main St., Jacksonville, Ill. 62650.

must elect to submit a simple, written application bearing his name, ward address, and a check mark indicating "I apply for a job in the workshop."

Second application: purposeful, non-stress interview. After a short period of employment in the program, the patient-employee becomes eligible to enter the workshop's "promotion program." This is a group, off-grounds activity concerned with community and social adjustment preparation. The patient learns of this program and his eligibility officially through the workshop personnel staff. Patients can earn successive increases in workshop wages by participation in the program. More importantly, the "promotion class" is a status group among his co-employees, with appealing program activities as well as wage advantages to elicit the patient's interest. To enter the program, the patient-employee must be registered with the local Division of Vocational Rehabilitation (DVR) office, which finances it. When the patient is ready to enter the "promotion program," he must therefore complete an interview with a DVR counselor, who prepares his client-registration form with him.

Third application: motivated, non-stressful application and interview for work assignment of choice. Patient-employees of the workshop perform not only subcontract factory work, but also many other duties needed to keep a company going—janitor work, stock work, payroll work, etc. Each patient spends about 80 per cent of his time on the subcontract production work and the rest on some special assignment. The new employee is given a variety of special assignments, adjusted to his work potential—e.g., he may sweep, ring the timekeeper bell, or calculate wages during different weeks. After gaining experience in a variety of such special assignments, he is

given the right to choose a preferred assignment.

To obtain a preferred assignment, with a wage increase, the patient must make application to the workshop staff. This involves completing a more detailed written application than his first one and arranging an interview with his hospital rehabilitation counselor. The main criterion for this application is "E for Effort"—that is, if the patient seems to be making an earnest effort to complete the written form and conduct the interview well, he is given the requested special assignment; his effectiveness and skill in this application are evaluated, but do not interfere with acceptance. The interview should determine the patient's motivation for a wage increase and chosen assignment; real effort is required to complete the application blank and participate in the interview.

Fourth phase: motivation to improve job-application effectiveness. The patient is now holding down a special assignment of his preference; he may apply for changes in special assignment by the application procedure described above, if he wishes. He is also now attending the "promotion class."

As a next step, he is told that he can obtain a major wage increase and other meaningful advantages if he succeeds in meeting the next requirement: making application for a special assignment of his choice at a competitive level of application. For example, if he can make a competitively successful application for the laborer job of empty-carton breaker (a popular special assignment), he can get this as his regular job, with wage advantages. If he wants to become a senior payroll clerk (a high-status assignment), he can get this post, at higher wages, if he can make a successfully convincing application for it. The point of

this step is to motivate the patient to improve his job-application skill for the sake of a position of his choice.

Fifth phase: formal training for the planned competitive application. One patient has decided to apply for a regular post as floor sweeper; another, as senior payroll clerk. The promotion program teacher now works with them in preparing for a more demanding job-interview for their particular choices. For this purpose, she collaborates with the patient's counselor, who (in step 3 above) has obtained diagnostic information on the patient's strengths and weaknesses in job-application situations. Thus, in the promotion program, the patient now studies and practices his job-application effectiveness for a particular workshop assignment, with meaningful objectives.

Next application: purposeful application that entails competition and controlled stress in an in-group setting. The patient, when ready, makes formal application to the workshop management staff for assignment to the selected job, at a competitive level of skill. He must complete a written application appropriate to the work and submit to an interview adequate to obtain acceptance, perhaps with an unfamiliar interviewer. The workshop interviewer must decide, "He is trying for the clerk job. Would I really hire him for such work?" The demands of this interview, both with respect to written application and interview performance, are greater than previously, the objective being to bring the patient to the point where he makes at least a passably acceptable application by outside standards.

Final phase: "real," outside applications. The patient is now holding down a special assignment of his preference in the workshop under competitive conditions—that is, his work is meeting standards promising for

outside work in that field. As part of his discharge plan, when it is developed, he is encouraged to begin seeking work outside the hospital. With assistance or guidance as needed from the promotion program, the hospital counselor, or local DVR counselor, he now begins to apply to concerns outside the hospital. Hopefully, his skill in applying for work has been increased by the application-training experiences associated with his workshop employment choices.

These steps provide one example of a special sequence for patient training as developed in the workshop plan from school-system concepts.

In relation to the educational-psychology principles involved, the following aspects of the technique are significant:

1. *Goal:* We have an explicit ultimate goal in the training—for the patient to choose an outside job and participate in a successful interview for it. In arithmetic terms, we might begin by saying we want the pupil eventually to learn how to perform long division, or the mechanism of square root.

2. *Starting level:* Given an explicit goal, we also have an established starting point pretty far from that goal—in this case, a patient who is unprepared, perhaps fearful, perhaps inept, with regard to applying for a job. By analogy, in language instruction we begin with a pupil who knows what reading is but cannot read.

3. *Stepping stones:* The crux of the technique is that, between the starting point and the goal, we plan an explicit series of experiences or "lessons." This is different from the sheltered workshop practice of providing training through unstructured experiences. We stress here training as a structured series of lessons or experiences. This is comparable to the textbook sequence of topic coverage to develop a given knowledge or skill. Our training se-

quence, then, provides a step-by-step path from starting point to goal.

"Pedagogy" is derived from the Greek language and the ancient Greek practice of having a slave lead a child to school, and retains the connotation of leading the pupil along a path. This principle is explicit in the seven-step sequence here described. Unless steps and sequences can be specified, like stepping stones, one has not developed a true training plan in the sense that training is something more than unguided experience.

4. *Successive levels of demand:* The steps provide for progressively increasing levels of skill and complexity. The written applications required of the patients proceed from less to more detail, from lesser to greater standards of adequacy. The interviews proceed from simple to more stressful. The job-choice situations develop from a simple go-to-work decision to choices of preferred assignments, and thence to choice with a competitive-demand aspect. The principle here is that of successive levels of mastery in building skills—as when a pupil begins with understanding simple addition and proceeds through the acquisition of successive skills to understanding of long division.

5. *"Whole pupil" aspects:* Certain broader aspects of school methodology are also invoked in the kind of sequence described. "Instruction" is not simply a routine expository matter. The training takes place in a motivated, purposeful situation; it involves a "lab" aspect (the workshop employment situation) and a group activity of a club or social nature (the promotion program), as well as direct, formal instruction—analogous in this respect to the "whole pupil" milieu of modern school organization.

The education model sequence described here is one facet of a special discharge-preparation program in the workshop system at Jacksonville State Hospital. It should be understood that the primary time of the patient-employee for whom discharge is contemplated is devoted to production work on industrial subcontracts, with the objectives of proving or improving job-holding habits and attitudes. Started by the hospital rehabilitation department in 1965 as a small pilot experiment, the project is currently serving 150 patients as part of an expansion program with a three-year, \$325,000, Vocational Rehabilitation Administration grant. In 1968 the workshop program of Jacksonville State Hospital was named recipient of the Francis J. Gerty Award (treatment category) of the Illinois Department of Mental Health, signifying its selection as the state institution making the most outstanding contribution to treatment for that year.

The technique of a special sequence for job-choosing and job-applying, modeled after school-system education methods, can be adapted to other appropriate psychological goals of rehabilitation. To apply the education model, one needs to study the training task in terms of goals, starting points, planning of sequences, successive skill levels, and patient involvement in the total learning situation.

The situation of the rehabilitation specialist seeking to prepare a sequence using the education model is similar to that of a teacher about to prepare a new course. The interested specialist who approaches the planning task in this light will find that numerous aspects of rehabilitation work can utilize training sequences based on the education model.

S. Steven Rosner M.P.H.

Problems and Needs in Rehabilitation

Everyone in the helping professions pays lip service to the need for adequate rehabilitation of disabled persons, but the provision of needed services to these people is woefully lacking. Most of our mental hospitals have been without any rehabilitation services or staff trained in this work. Only a handful of the 21,000 patients in Massachusetts state mental institutions are today benefiting from any services of this kind. Even among the 6,800 discharged in 1967, very few are receiving any rehabilitative help or counseling. No wonder that readmission rates are over 50 per cent and the costs of mental illness are increasing at a staggering rate!

However, some progress has been made, especially in the past year (1968). Rehabilitation services for the mentally ill were not even provided in most states, including Massachusetts, until the late 1950s, despite the inclusion of such services in federal legislation in the late 1940s. According to the annual report of the Massachusetts Rehabilitation Commission for 1965-66, about 20 per cent of its cases had a primary diagnosis of psychosis or psychoneurosis; yet

that year only one of the state's mental hospitals had rehabilitation counselors on its staff. Since then, several of the hospitals have had counselors assigned to them. In other words, Massachusetts is just beginning to provide rehabilitation services for the mentally ill, although several other states have had counselors working in their state mental hospitals for more than ten years.

A major problem has been the lack of trained staff to do the job. The Massachusetts Rehabilitation Commission had only about 70 rehabilitation counselors a year ago. Yet its intake was over 13,000; more than 1,300 cases were already on hand. Obviously, there were not enough counselors to begin to do the job, certainly not in the mental hospitals or community mental health centers.

Unlike other services, rehabilitation has suffered not from lack of available funds, but from lack of programs to utilize several million dollars in federal funds that could have been allocated if state matching funds had been appropriated. The state legislature did not appropriate such funds because the programs were not submitted to it. As a result, there was a rehabilitation gap—brought about by lack of foresight, planning, and a determined effort to gear up rehabilitation services so that every available dollar could be used to restore disabled persons, including the mentally disabled, to functional community living.

Mr. Rosner is executive director of the Massachusetts Association for Mental Health, Inc., 38 Chauncy St., Boston, Mass. 02111.

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MENTAL HYGIENE

In the past year, the Massachusetts Rehabilitation Planning Commission has proposed comprehensive programs, at the community level, in all 37 geographic areas first delineated in the Comprehensive Community Mental Health Act of 1966. These programs would ensure the availability of services to handicapped persons in all parts of the Commonwealth.

Implementation of the recommendations of the Planning Commission will need a high priority from the executive and legislative branches of state government and from the Rehabilitation Commission and other relevant agencies. Unless the recommendations are acted upon quickly and effectively, Massachusetts stands to lose great sums of federal rehabilitation money, which, according to the Planning Commission, will increase from about \$6 million in 1967 to about \$18 million in fiscal 1970 and to more than \$40 million by fiscal 1976. Beginning in fiscal 1970, the federal government will put up four dollars for every dollar of state funds, which will require the state to raise its share from \$2.3 million for the present fiscal year (1969) to \$3.6 million for fiscal 1970. Anyone familiar with the ways of state government, both in the governor's budget office and in the house and senate ways and means committees, realizes that this kind of increase will require a great effort, backed by well-reasoned plans and proposed services from the Rehabilitation Commission, and wide public support.

What is needed and what can rehabilitation agencies buy with \$18 million or \$40 million?

1. Increased staff is needed. The Planning Commission called for a fourfold staff increase by 1975. By 1970, it should be possible to double the staff to provide mental health counselors in all regions and in all residential mental health facilities run

by the Department of Mental Health. These counselors will need to be carefully selected. They should be well trained in mental health counseling and, therefore, not afraid of working with the mentally ill or worried about chalking up a score of so many placed in private employment, etc. This means getting more counselors trained in academic programs offering specially designed courses, and taking advantage of the federal money for graduate study and training programs.

2. Increased consultation by skilled psychiatric consultants should be made available to the current staff in mental health counseling. The Massachusetts Rehabilitation Commission has been providing this kind of tutorial program in its district offices; it should reach all counselors, since medical and mental health problems are often intertwined.

3. At the same time, a more determined effort is needed on the part of the governor's office and the legislature to see that positions for counselors are upgraded and higher salaries approved, starting with the commissioner's salary. It is disgraceful that counselors' salaries in Massachusetts and other states start as low as \$6,800 and go to a maximum of \$8,500 after five years! And the agencies are expected to recruit people with a master's degree!

4. As the area mental health programs develop, we should hope that at least one mental health rehabilitation counselor will be assigned to each community mental health center or area. The experience gained from the federally financed project in the Roxbury, Massachusetts, District Office should help in planning these services. This federal grant provides full-time psychiatric consultation for the mentally ill and will plan to make rehabilitation services available in the Boston University Hospital Mental Health Center.

5. During the past year, the Rehabilitation Commission has moved rapidly in establishing, within Massachusetts state mental hospitals, sheltered workshops in which patients can work and earn money. State rehabilitation agencies should utilize the sheltered workshops in the community more fully; many of these workshops could take more mental patients if they were referred to them. They should set up terminal or extended workshops in which people not able to enter private industry could still be in a work setting, doing useful work and receiving pay for it.

Private industry has demonstrated a singular unwillingness to hire ex-mental patients. Studies by Olshansky and others have shown that little can be expected from industry, especially with respect to ex-mental patients who have not had previous work experience. The British have for many years had a law requiring companies of a certain size to employ the handicapped up to 2 per cent of their working force. If such a law is not feasible in the United States, we should at least expect industry to provide enough subcontracting for sheltered workshops. The Rehabilitation Commission is best equipped to develop these contacts.

6. Rehabilitation agencies should be much more flexible in assisting mental patients to readjust within the community, despite a poor prognosis for their ever being able to engage in gainful employment. As the Massachusetts Rehabilitation Planning Commission has noted, the public rehabilitation program must be concerned with the total life functioning of each handicapped client and, at the same time, keep his employability as an objective. This would mean helping the client to make adjustments back in the community and making it possible for him to live in the community even though he may not be well

enough to actually hold a job. The Commission proposes that extended workshops in all regions of the state should initiate day activity programs stressing "self-care skills, recreation and social interaction."

7. State rehabilitation agencies are beginning to play a role in supporting halfway houses, in which patients can live on leaving the hospital. Other housing should be provided, on a group living basis, for patients who may never be able to live completely on their own, or even in a foster-care home. Active support for providing more foster-care homes is necessary. The Massachusetts Association for Mental Health and the Department of Mental Health, in a recent survey of the 12 state mental hospitals, found that more than 500 additional patients could be placed in foster-care homes provided the per capita cost of \$5.50 a day were appropriated. Rehabilitation departments could consider taking over this program for the state hospitals, as an adjunct to their halfway house program.

The Massachusetts Rehabilitation Commission has taken a forward step this year in supporting services for ex-mental patients at Boston's Center Club. However, it has limited this aid to pre-vocational or vocational guidance and has not felt able to subsidize services concerned with the social and recreational needs of mentally handicapped people. We hope that the Rehabilitation Commission will move in this new direction and assist social clubs now being run by our local Mental Health Association chapters in many parts of the state, from Roxbury to Salem and Northampton. State rehabilitation agencies in Pennsylvania, New York, Maryland, Alabama, and many other states are now supporting such services; and Massachusetts and other states should certainly follow their lead.

Allen Hodges, Ph.D.

How NOT to be a consultant

The consultation process, an essential element of a comprehensive community mental health center, is fast becoming the chief technique of the mental health professional who attempts to facilitate change in individuals, agencies, or communities.¹ The professional literature dealing with the subject of consultation often expounds a philosophy and role for the consultant as well as describing techniques and/or processes used by the consultant in certain settings. Gilbert has wisely pointed out that the consultant's role and process are inextricably dependent upon the *function* which the consultant is expected to perform.²

It may well be that the urgent need to develop a technique such as "consultation" has encouraged rapid theory development without the benefits of basic observations that might occur with time. For example, one can become deeply engrossed in debates over which technique is best, what role should the consultant assume, or what should be the philosophical creed of the consultant. To focus exclusively on such abstract levels of concern is to ignore the

basic fact that consultation is an interpersonal process between consultant and consultee(s), based upon mutual respect and acceptance. The consultant's "personal stimulus value" then becomes a significant factor in the success or failure of the process labeled "consultation".

Very little can be found in the literature pertaining to the personal stimulus value of the effective consultant or of the effective consultant's *modus operandi*. Kazanjian, et al.,³ list several suggestions that contain "do's" and "don'ts" for professionals undertaking the consultation role. It may well be that a productive area for future research would be to identify the traits and/or characteristics of successful consultants as perceived by their clients. At our present level of knowledge, however, the science and/or art of consultation is somewhat analogous to child development in the 1940s, when it was much easier to tell parents what *not* to do. Dallavaux in 1946 produced a humorous book entitled, *How to Raise a Brat*,⁴ based upon this approach.

With the recognition that our current knowledge concerning the successful consultant's personal and social attitudes and social skills are quite limited, let's take a humorous look at some of the negative traits which are readily identified.

Dr. Hodges is Associate Regional Health Director for Mental Health, NIMH, Dept. of Health, Education and Welfare, Regional Office VIII, 9017 Federal Building, 1961 Stout St., Denver, Colo. 80202. The contents of this article reflect solely the opinions of the author.

Negative Attitudes

There seem to be at least three perverse beliefs and attitudes which, if present in the consultant, guarantee that the consultation process will be loused up.

1. The consultant's knowledge is sacred and, he, as the guardian, can share it with only the anointed few.

2. Personal needs (prestige, respect, adoration, etc.) are to be fulfilled through contacts with clients.

3. The image of "the expert" must be maintained at all costs, conveying to the client that he is inferior and that the consultant could do his job much better if he were in his shoes.

Specific Techniques

There are certain specific techniques that convey to clients these three negative attitudes, sometimes more effectively than words.

1. Be late for appointments. Keep them waiting, for their time is not very important.

2. Do not listen to the client's gibberish. Interrupt frequently in order to press your own ideas upon him.

3. Through innuendo, disparage the goals of the organization for which the consultee works.

4. Convey the threat of power, retaliation, and raw authority if the consultee doesn't do what you order him to do.

5. Start the consultation process, not with the problem as the consultee sees it, but with the problem as you the consultant see it. (Make him march to the beat of the consultant's drum.)

6. Impose socially on the client. Freeload frequently by visiting him at meal times. Make him feel guilty if he does not pay you the necessary respect, even in social situations.

7. Finally, violate in your behavior all the platitudes to which you give lip service.

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Laurie Lomba

The Unrecognized Professional

The community mental health secretary is a specialist. The demands made on her are unlike those made on secretaries in other fields. She may find herself in close contact with people ranging from the uneducated and culturally deprived to high-ranking government officials, and she must be at ease with both. She must be more than a typist, a stenographer, or, for that matter, a secretary: she must be a dedicated mental health worker.

She is, in effect, a window through which the community sees the mental health professionals and through which, if they will but look, the professionals can see into the community.¹ She frequently provides the help-seekers' introduction to the concept of "community mental health" since she is usually the person who initially interviews patients and their families. She is expected to bring to her job initiative, tact, judgment, dependability, and a considerable degree of maturity.

The community mental health secretary must know the community she serves as

part of the mental health team. Each community will dictate its own needs, and it is up to her to meet them within the framework of her job. She must keep her finger on the pulse of the community; she must be aware of all legislation affecting it; above all, she must develop an informed mind that places her on the team of professionals serving the community.

No "catchment area" will have a single culture, but will comprise a number of subcultures and social structures. Though the mental health secretary is not expected to be a sociologist, her understanding of the community and its social influences on those she serves will add greatly to her value to the helping professionals and to the community.

There are as many roles for the secretary in community mental health as there are clinicians and administrators to define them. One professional may look upon his secretary as someone who answers his telephone, sends out his bills, makes (and breaks) his appointments, and keeps his files in reasonable order. Another may see in his secretary an associate to be treated like any other staff member, a person who may live in a world removed from his own, one in which she is not surrounded by his colleagues, but who actually lives in closer proximity to those he is pledged to serve. This person will usually see in his secretary one who, with his help and guidance, can become an asset in a field in which new

Miss Lomba is administrative assistant of the Baltimore Inner City Community Mental Health Program, 645 W. Redwood St., Baltimore, Md. 21201. The program is under the aegis of The Psychiatric Institute of the University of Maryland School of Medicine and the Maryland Department of Mental Hygiene. Miss Lomba is currently president of the Community Mental Health Associates. This article is adapted from an address delivered before the Association at its general session in March 1968.

specialties are constantly being developed and in which the professional mental health secretary can find fulfillment if she is willing to invest her energies.

Once she chooses the field of community mental health, the secretary's job ceases to be a 40-hour-a-week one. She may find herself in overalls working side by side with the people in the community on a special project, or attending seminars, official functions, or even protest rallies.

The role the mental health secretary plays will be dictated by the demands of the center in which she serves and the community in which the center is located. The type of center in which she is employed will have a great bearing on her functions. The size of the staff will be a determining factor. In a relatively small center, the secretary may wear many hats: she may function as receptionist, interviewer, file clerk, coffee-maker, switchboard operator, statistician, cartographer, answering service, public relations person, finder of missing persons (patients *and* staff), typist, confidante, painter and carpenter, soother and hell-raiser. She can count on only two things—being overworked and being underpaid. In a large operation, she may be limited to work within a particular department or division. Still, many of the above hats must fit.

However, since the community mental health concept is so new, chances are that, although eventually the center may grow into a large entity, it will have its beginnings in a small division within the department of psychiatry of a general or university hospital.

It is, of course, most beneficial to the personal and professional growth of the secretary if she is able to join the staff at the beginning of the program. She will then be "in" on the growing pains and will herself grow with the program. She can

be a vital part of the program and, indeed, should be an important member of the team. This means, however, that other staff members must permit her to utilize all her professional and personal skills and to accept the responsibilities she is capable of assuming.

If the secretary is to be effective in dealing with, for example, a culturally, socially, and economically deprived urban population, she must have a degree of empathy that nothing short of personal involvement can provide. In addition, in cases in which she is "on the team," she must be endowed with the understanding of a wife, the loyalty of a dog, and the optimism of a ten-year-old. These qualities she must display primarily toward the clinical professionals, but she must also use them to help the patients. At the start, a basic knowledge of human relations will suffice. On this the professional community mental health secretary can build as she becomes more knowledgeable concerning other staff members, the individual patients with whom she has frequent contact, her co-workers, and the area her center serves. Often she finds herself playing the role of father-confessor to a tired staff member who has had a particularly trying day. At other times she may be a listening post for a frustrated and possibly angry patient. However, she must never assume the therapeutic mantle of the helping professional. Rather, her role in this instance is that of "stop-gap" until the patient can be seen by the appropriate person.

The other side of the coin, however, is presented by those who find the presence of a capable, well-informed, articulate secretary threatening. Such people, perhaps because of their own ill-defined roles or because of feelings of inadequacy (real or fancied), can harm the program in many ways. The problem that concerns us here,

though, is their inhibiting the secretary to the point where her experience and training are wasted. If the situation is irremediable, the contributions she can make as a professional mental health secretary are negligible. She is then faced with the alternative of staying on as a stenographer or leaving for a position in which she can utilize her professional skills.

The role she plays within a given program depends as much on the secretary's ambition and expertise as on the position of the person with whom she works, the attitude of the rest of the staff, and the program's philosophy and general implementation. In any case, at whatever level she enters the program, the community mental health secretary will bear part of the responsibility for the formulation of her own role and that of the community mental health secretaries of the future.

We are now at a professional crossroads. A step forward is being taken by the Community Mental Health Associates. This fledgling organization has embarked on a pilot program to provide specialized training for its members. As yet unfunded, the organization is proceeding with a tentative program consisting primarily of a series of visits to community mental health centers in the Baltimore-Washington-Philadelphia area. Once funding is available, a more ambitious, three-year training program will be launched. The culmination of this program will be a manual for the community mental health secretary. The training program will, hopefully, provide the nucleus of a nationwide corps of well-trained clerical personnel to staff not just the community mental health centers, but

all community-oriented facilities devoted to the well-being of the public.

One of the most worthwhile outcomes of the formation of the Association to date has been an increased awareness on the part of its members of many other relevant agencies. Present participants come from health and welfare agencies; federal agencies concerned with mental health; city and state mental health facilities; private, state, and university hospitals; and a variety of mental health organizations. An exchange of information and services has taken place among the participants that, for some inexplicable reason, had been missing at higher levels of communication. A small directory prepared by one member was augmented and now serves all the agencies represented. A master calendar of events is being considered by the Baltimore area unit. This calendar will list events scheduled by psychiatric societies, hospitals, etc. that would be of interest to the psychiatric community. Eventually the Baltimore unit will function as a clearing house to help avoid the scheduling of important meetings, seminars, and conferences at conflicting times.

The community mental health secretary can be of assistance to the clinical professionals by taking over many details with which they are constantly burdened and which she, as a capable person, can handle. Thus, by utilizing one of their most valuable yet most unrecognized assets, the clinical professionals can have an added measure of time to devote to their work in the community. The competent mental health secretary can indeed be an important member of the community mental health team.

George Krieger, M.D.

Training Nursing Assistants for a Subprofessional Role

Despite the hopes of, and the efforts at recruitment by hospital administrators, it has become apparent that the number of professionals (i.e., psychiatrists, psychologists, social workers, and psychiatric nurses) available for the care of the mentally ill in our public psychiatric hospitals is not increasing. Whether the financial advantages of private practice or the prestige of working at a private institution or in an academic setting is responsible is not clear; but, whatever the cause, the net result is that our dilemma is becoming progressively worse.

Different approaches to solving the manpower problem are being tried. For example, some hospitals and community mental health and neighborhood service centers are developing and using the services of college students,¹ housewives,² and indigenous non-professionals³ in tasks usually performed by professionals. Although the experience in such efforts is still limited, some of the results have been exciting and effective.

I believe we have a comparable source of potential manpower for an analogous subprofessional role in our hospitals' nursing assistants, or attendants. As a result of major changes in institutional practices (e.g.,

Dr. Krieger is chief of the Psychiatry Service at the Veterans Administration Hospital, 3801 Miranda, Palo Alto, Calif. 94304, and is associate clinical professor of psychiatry at Stanford Medical School.

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the use of open wards, of psychotropic drugs, and of the principles of social psychiatry), the traditional role of the nursing assistant is becoming obsolete. At this point in time, in many institutions, nursing assistants (along with their supervisors) are confused and struggling to find a more satisfactory function for themselves and a role-identity.

My proposal to train and use the nursing assistants as subprofessionals is based on several assumptions about goals:

1. Stated in simplified terms, our goal in treatment is to help the patient learn more effective ways of dealing with his problems in living and better ways of satisfying his needs. This learning is best accomplished through experiences in relating to other people who have a humanistic, therapeutic attitude toward the patient and who can help him correct his distorted perceptions of himself and others.
2. Whatever happens to a patient in the hospital can be therapeutic or antitherapeutic. Therapeutic interactions can occur not only with professionals, such as psychiatrists or nurses, but also with nursing assistants, ward secretaries, janitors, and other hospital personnel.
3. Although our new psychotropic drugs are very helpful, they don't solve social problems. The drugs are poor substitutes for human encounters with the hospital staff.

Our traditional methods of training nursing assistants are archaic for the 1960s. For

one thing, they are directed too much toward training the nursing assistant for the custodial role of the past rather than the new, more therapeutic role of the present. Traditional training courses place far too much emphasis on such matters as the hospital's rules and regulations; the danger of assaults and elopements by patients; the physical care of patients—feeding them, bathing them, giving them enemas, etc.—procedures that require skills appropriate for a medical-surgical ward but rarely, if ever, needed on an active psychiatric ward; and doing things for patients rather than helping them to help themselves.

A great deal of emphasis currently is placed on didactic lectures, despite the fact that research has repeatedly shown this to be the poorest way to teach modern psychiatry or to change attitudes. Much psychologic theory is being taught *in vacuo*, and the nursing assistant is usually unable to see the application of these theories to his day's work. In addition, these theories confuse him and inhibit him from spontaneous interaction with his patients.

In contrast to the above outmoded practices, a more appropriate modern training program, particularly one directed toward preparing nursing assistants to function as subprofessional therapists, would be guided by the following concepts:

1. There would be constant emphasis on the idea that the main treatment thrust is by staff, at all levels, interacting as much as possible with patients. These interactions would be characterized by mutual respect and an effort at understanding each other's needs and feelings. Such subprofessional-patient interactions might be labeled "therapeutic conversations."

2. The training would include relatively little didactic instruction, but a great deal of supervised experiences with patients. There would be many informal discussions

with peers and instructors about psychologic principles and techniques; more importantly, these principles would always be directly related to the prior day's work experience with patients on the wards rather than viewed as abstractions. Thus the training of the nursing assistant would be more experiential and emotional than cognitive, and theory and practice would be brought closer together.

3. We should be making more use of audio- and video-tape recordings for relatively immediate playback of interviews with patients, small group meetings, or ward community meetings in which the nursing assistants have been participants.⁴ These devices are powerful teaching aides whose capabilities are only just beginning to be recognized. Playbacks offer the students and their instructors multiple opportunities for a careful and sophisticated review of their techniques and case material. These reviews, by their immediacy and the nature of the medium, create vivid and lasting impressions. They can increase awareness of subtle behavioral cues, of the multiple levels of communication, and of people as therapeutic instruments.

4. We must make the nursing assistant a truly active member of the multidisciplinary, cohesive, ward treatment team rather than continue just to give lip-service to this concept. Along with the professionals, he should be intimately involved in the daily evaluations of the patients' progress and the planning of ward programs. Along with the other members of the team, he should share a sense of responsibility for decisions affecting the patients; his active participation in such meetings as "psychological autopsies" should be encouraged.⁵ In essence, our goal is to achieve a more collaborative relationship with the nursing assistant rather than the typical subordinate one.

5. Our proposed program would give high priority to encouraging nursing assistants to become participants in research. For example, by filling out rating-scales on his patients, the assistant is indirectly taught to be a more perceptive observer and to be more sensitive to the feelings of others.

6. We must encourage the nursing assistant to feel free to be innovative, to develop his own unique potentials, his own personal style of interacting with patients rather than to try to be a carbon copy of some professional. In fact, his similarity to his patients in background, values, and even language may often reduce the social distance that may separate the patient from middle-class professionals.

7. All these concepts hopefully would occur in a psychologically benign setting in which there would be, as often as necessary, a great deal of corrective feedback, support, and positive reinforcement for the nursing assistants' efforts to function in this new role.⁶ Obviously, we must be prepared for problems, blunders, and failures; but the price is well worth the dividends it will bring.

It is recognized that there are many obstacles to the implementation of such a program. The blurring of role definitions may challenge comfortable status hierarchies, the professionals sense of expertise, and the maintenance of the *status quo*. Almost any policy or status change can seem strange and threatening to staff, and will be resisted overtly or covertly to some degree. Resistances are usually rationalized by concern about "breaking the regulations," "forgetting our customary medical responsibilities," or degrading the quality of services available. However, if these proposed changes in the training of nursing assistants are fully discussed with the involved personnel and are introduced slowly, acceptance and success are more likely to result.

Some objectors to this sort of program have pointed out that our nursing assistants typically are people who are non-verbal, are of limited educational background, and, occasionally, are of limited intelligence. Nevertheless, experience has demonstrated that, if psychologic principles can be presented clearly and in sufficient detail and are spelled out in operational or behavioral terms, they are within the intellectual reach of these people, despite their limitations. Moreover, for our treatment purposes, we are more concerned about the nursing assistant's warmth of personality, human interest in his patients, and ability to be a real person than about his intellectual capacity. Actually, some of our talented and dedicated nursing assistants have already, intuitively, been functioning in this new role of therapist.

It would seem that a training program such as the one here described and use of nursing assistants as subprofessionals could be of benefit in a number of ways. Patients would get more out of their hospitalization experience by helpful encounters with nursing assistants functioning as subprofessional therapists rather than just as guards, custodians, or caretakers. Nursing assistants would enjoy their work more and would feel more useful.

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Points of View

Fred H. Frankel, M.B., D.P.M.

Perspective on Community Mental Health and Community Psychiatry

Conceptually, the community mental health movement appears to have started somewhere in the mid 1950s when there was much dissatisfaction and disenchantment on the part of many psychiatrists as well as the public regarding the effectiveness of the care of the psychiatrically ill in the United States. In **Action for Mental Health** the Joint Commission on Mental Illness and Mental Health drew attention to the need for a reorganization of mental health services on a large scale, and emphasized its concern regarding the finances and manpower required for an effective change.

The report of that body was followed by the Community Mental Health Centers Act of 1963 and by subsequent surveys and legislation in several states, all of which encouraged the establishment of community mental health centers along fairly specific lines.

From a clinician's viewpoint we might say that the community mental health movement involves the following three major dimensions:

a) Treatment

This is to be offered to all members of the community and is to be organized within the community, providing ready access to diagnostic evaluation, treatment and after-care programs. The aim may be seen to be a major reform of mental hospital practice, geared towards keeping patients in the community as long as possible, hospitalizing them only if necessary in facilities located within the geographical area of the community, and returning them to their lives within the community as soon as possible. The status of patients is to be flexible, in order that out-patients may become day-patients and inpatients and again out-patients with the least possible obstruction. The principle of continuity of care is spelled out to prevent patients from being lost between services. The system involves the professionals traditionally concerned with the care of the psychiatrically ill in addition to non-professionals and agencies who all have to work within an organized structure of interrelating services.

b) Prevention

Prevention is to be offered by means of consultation and early detection which can

Dr. Frankel is a psychiatrist at Beth Israel Hospital, 330 Brookline Avenue, Boston, Mass. 02215. He is an assistant professor with the Harvard Medical School.

be built into programs offered to local schools, industrial concerns, religious organizations, settlement houses, etc. These programs offer an opportunity for the recognition and the anticipation of crises in the life cycles of the citizens, and also offer by means of after-care the opportunity to recognize and perhaps prevent relapses. Using the appropriate terminology, the prevention described here is of the secondary and tertiary kind.

c) Primary Prevention or Parapsychiatric Issues

This is an area in which the community mental health movement logically becomes involved and includes attending to the problems of urban renewal, poverty, limited job opportunities, inadequate vocational training, poor education and housing and race prejudice. It also includes spreading enlightenment regarding delinquency, drug abuse, homosexuality and other thorny issues that disturb the community.

With my background of general psychiatry in Johannesburg, South Africa, many of the aforementioned activities seemed an acceptable part of my work commitment when I arrived in the U.S.A. in 1962. For nine years prior to that I had, in addition to offering treatment to patients, counselled their parents and spouses, provided consultation to industry and offered emergency care or assistance when called upon to do so by patients or medical colleagues. I discovered that whatever I had been doing outside the diadic relationship was regarded by many in the U.S.A. as "community psychiatry". As a result, I was assigned the task of co-ordinating a psychiatric emergency unit for two and one-half years,^{1, 2} and of consulting with senior nursing home staff and a community agency for two and one-half years in an attempt to educate the personnel in the understanding

of human behavior. I also spent many hours participating in discussions pertaining to the development of community mental health programs in the State of Massachusetts.

I soon became aware of the unfortunate dichotomy of good and evil that seemed to prevail, and that was captured by the phrases and shibboleths of the community mental health environment. I became increasingly mindful of a popular item in the entertainment world, which, when parodied, might read as follows:

- Innovation is a clean, Traditional is a dirty
- Mental Health Workers are a clean, Disciplinary Boundaries are a dirty
- Change is a clean, anything to do with Status Quo is a dirty
- Catchment Area is a clean, Dynamic Psychiatry is a dirty
- Shop Front is a clean, Hospital is a dirty
- Cultural is a clean, Freudian is a dirty
- Non-professional Indigenous Worker is a clean, Middle Class Doctor is a dirty
- NIMH is a clean, Institute is a dirty
- Prevention is a clean, Treatment is a dirty
- Free is a clean, Fee is a dirty

I struggled with many of my colleagues to try and define more clearly where I stood in this major upheaval of loose definitions and impatient haste to bring about change, and in March 1967 made use of two descriptions which helped me roughly differentiate between what I prefer to consider "community psychiatry" on the one hand and "community mental health" on the other. They were included by me in a memo submitted to the chairman of the Metropolitan Mental Health Planning Committee of Greater Boston at the time that committee was

planning a conference for the community agencies of greater Boston to meet with professional representatives:

" . . . the terms 'community mental health' and 'community psychiatry' are not synonymous. To talk of mental health when we mean mental illness perpetuates the refusal to come to terms with the ugliness of reality. Although the terms may overlap in some areas, they are not the same. 'Mental Health' refers to criteria of health; it embodies methods whereby health can be maintained and programs whereby illness can be prevented; in part it relies on caretakers in the community drawn from several different disciplines; it involves among other things job opportunities and vocational training; and many of its activities automatically interact with community political issues such as urban redevelopment, social reform, poverty and education. 'Psychiatry' deals with the diagnosis and treatment of illness, and community psychiatry emphasizes the vital importance of bringing diagnostic and treatment programs to the community to facilitate earlier detection, more rapid and more effective treatment, after-care, rehabilitation, and thereby more adequate prevention too.

"To encourage, at this stage, the confusion of these two vitally important fields of endeavor is to render a disservice to those who are psychiatrically ill or who may become so. Consultation for, and education of, the community; programs for early detection; after-care programs; and the several aspects of prevention which can be considered largely mental health responsibilities will be effective only if they have the backing of fully equipped clinical psychiatric programs that include the full range of psychiatric treatment modalities—modalities that include the accumulated wisdom of the biological, environmental and psychoanalytic schools of thought."

It is apparent from my description that I tend to want to separate out the professional commitment of psychiatry (and this does not mean the individual personal commitment) to treatment and prevention, from its commitment to the parapsychiatric area linked to primary prevention. This does not mean that I believe psychiatry has no insights to offer councils that are concerned with such problems, but it does mean that our professional contribution to those areas needs to be more modest because our professional opinions are based on scanty evidence and we hold no monopoly on knowledge. Whereas psychiatric understanding of human behavior should influence decisions regarding those matters, there are other disciplines as concerned and as well or better equipped perhaps to direct the changes that should take place.

The descriptions quoted above allow me, I believe, to see some of the turmoil in perspective, and to recognize that what is spoken in the name of community psychiatry or community mental health is not all good—but at the same time is not all bad.

In conclusion I present the following comments and questions:

1. Community mental health is not a major breakthrough in knowledge but a reorganization and expansion of the system.

2. We need to learn to decant the spirits of enthusiastic liberalism from the substance of professional knowledge if we are to avoid disenchantment in both the political and the professional camps.

3. Why has there been this hurried massive expenditure of energy and money to innovate and introduce new programs throughout the country without first testing a few well chosen and well planned schemes?

4. How can quality care be provided if we undertake all at once to provide care in massive quantities, and where will all the

necessary appropriately trained personnel be found?

5. If the answer to the question above lies in the use of "paraprofessionals", "non-professionals" and "indigenous mental health workers" why was more attention not paid previously to how these groups were to be trained and prepared for their roles? The form of consultation and education required to teach them has been poorly conceptualized, and from my personal exposure to personnel of high calibre in some agencies, it is my opinion that many of these well-intentioned people cannot be trained in haste at all other than to perform relatively simple tasks.³ What appears to have escaped the attention of the enthusiasts is that there is really no short cut to good patient care, and that very large numbers of adequately trained professionals will still be required to deliver or supervise the services.

6. My final comments concern the direction of psychiatry with yet another sub-speciality in the making, and what happens to the patient in all of this. Psychiatry has been split asunder for two decades, and only now are we beginning to see some repair of the breach between the neurophysiological-biochemical orientation on the one hand and the psychodynamic on the other. A pity it is that the sociocultural orientation has had to be developed outside of these two major streams, possibly to be taught in separate schools confined to the teaching of community psychiatry.⁴

How will such schools, or others that concentrate solely on an understanding of the biological or psychodynamic approach to individual patients, prepare students and residents for professional life in the real world? How do we protect the patient of

the future from the likely fate of his parents who, if they rang the doorbell of one psychiatrist's office would get shock, and if they rang the bell on the door adjacent would get psychoanalytic psychotherapy, irrespective perhaps of what would have been most appropriate for them? How, in other words, can we ensure that the whole of a patient's problem will be understood and dealt with by the system, and that the crucial environmental influences so correctly stressed by community psychiatry will be attended to in any regime of care that is prescribed for him?

How can we ensure that community psychiatry (my version of it) will articulate with and remain a part of clinical psychiatry, leaving the broader issues of legislation and political and social action to larger groups which should include representatives of medicine and psychiatry, but which also must have equally vigorous representatives of public health, sociology, psychology, education, the courts and many others?

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Donald Blumberg, M.S.W.

The Ex-Patient as Change Agent

As long as a mentally ill person is institutionalized his role as a mental patient will be clearly defined. He will identify as a patient and be treated as such. Changing the role and social milieu gives the patient a chance to evolve in the direction of ordinary living.

A system of halfway houses in the community supported by group oriented activity focusing on socialization, resocialization, recreation, activities, discussion, employment, pre-employment, social problems and emotional problems would help large numbers of the chronically and intermittently ill to live in the community, which, by definition, implies better social functioning. Behavior, says Wittgenstein, is imbedded in its situation.

Such a program would have obvious secondary and tertiary efficacy. It could also be useful in basic prevention on a primary level. The preventive program is based on two premises:

1. A basic constituent to mental health is social role behavior, which can be defined by the individual and society as adequate social functioning.

2. Two underlying conditions of mental illness are low self-esteem and social isolation, both of which are experienced in a

social field relevant to the perception and responses of significant others.

Both premises are transactional, i.e., involving a transaction between the individual and significant others in a social field. It is in the social field that the basic consensual validations occur which authenticate and support healthy and strong identity, or fail to do so. Commonly held attitudes and beliefs of the community regarding the behavior and status of the mentally ill are a significant aspect of such transactions.

The humiliation and isolation of the schizophrenic, for example, are reinforced by the response of others to him as "insane", "crazy", or an "ex-mental hospital patient". These scapegoat roles and low status designations have obvious hostile and segregating implications. Any primary preventive approach to the community must then aim at reeducation of the community in terms of understanding and attitudes. The present plan adds to this the development of social roles for ex-mental patients and others as change agents in the service of this end.

Clifford Beers, founder of the mental hygiene movement, is an ideal role model for this kind of an identity. Ex-patients could teach by word and behavior that mental health and illness are part of a continuum, that illness is intermittent, cross-

Mr. Blumberg is the director, psychiatric social work division, The Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. 21201

cultural and cross-class. The formerly ill or the intermittently healthy in certain situations could act as bridges to both the community at large and certain high-risk subgroups.

Ex-mental patients, with or without being identified as such, could enter groups either as members or co-leaders with any focus and be useful toward this end. It would require a high morale and feeling of social purpose that could only be supported by an organization adapted to such purpose—a Clifford Beers Institute for role training and program development that would in-

tegrate with the tertiary and secondary prevention programs of the Inner City Community Mental Health Program.

Finally, a variety of institutional and cultural change-agent roles should emerge from this kind of bold challenge to the status and treatment of the mentally ill. As groups of citizens involving ex-patients and those with no patient experience develop social action purposes and goals, the program would act to bring people together in socially useful ways and at the same time support their development as adequate role functioning individuals.

The Three Children of A Mad Woman

*To my eldest,
Lover of my life,
Dream of my hope
Hope of my dreams,
And nightmare
Of my failure.
Born the year of the Rabbit,
Oh, poor rabbit,
Whose eyes washed out to blankness
When mine dilated with fear,
With Fear—
When the doorbell rang.
My defeated,
My ever victorious,
My own.*

*To my youngest,
The sunshine
And moonlight
And starbeams of
My life.
Whatever roars and*

*Whistles and pounds in my
Glad, glad life
Come from his laughing cute eyes.
Sweetie pie,
Lover boy,
Dessert
In my desert
Repast.*

*To my daughter
Sweet sixteen,
Seductive hips,
Innocent sweet eyes.
Let me burrow among
Your tumbling black hair,
Smell the rose
Decorating your body
And dream again
Of long ago,
When I, too, was a princess.*

—Annie Wu

Rose Zeligs, Ed.D.

Do Therapists Play God?

Every family experience has different meanings and different memories for each member. Try the simple experiment of asking all members of a family to write down the most outstanding events they can remember that happened in the family during their childhood. Or, have them describe some special event. You will probably find that each one remembers different events and also has a different evaluation or description of what actually happened concerning a certain event. The amount of distortion existing in relation to reality can hardly be measured by anyone, since the personal experience of every member of the family is the most vivid and real to him alone.

To try to interpret another person's feelings and fantasies and what exists in his unconscious is a difficult and almost impossible task. To jump to conclusions about it without having the confirmation of the other person is wrong and may often be harmful.

It is arrogant to assume that the therapist, an outsider, knows more about a person than he knows about himself. To do so and tell him so represents an effort to make the person impotent and helpless. Therapists must respect the other person's privacy and his right to reveal or withhold his private personal thoughts and feelings. Therapists must always respect patients'

rights as human beings. If the human being was created to be able to keep his thoughts to himself, this capability must be present to serve the useful purpose of protecting his identity and personality. Repression, too, serves useful goals. The idea of thought control negates our feelings of freedom and the rights of the individual.

Therapists should refrain from trying to analyze every person they meet. Instead of dealing with such people on the basis of what they believe to be in their unconscious, they should carry on relationships in accordance with such an individual's manifest conduct.

It is only when there is illness that the surgeon uses X-rays, cuts open the body, gets under the skin, and digs and digs. Therapists sometimes need to perform psychological surgery on patients, but it must be done with the greatest care and consideration. Respect a person's unconscious. Don't be too sure you are right. Don't play God. Everyone is different and you may just be projecting your own feelings upon another person.

William V. Silverberg, M.D., says, "It is a precarious thing to come to a conclusion about what is or was in another person's mind, conscious or unconscious, until the other person is able to confirm it by his own words."¹

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Dr. Zeligs is a clinical psychologist in private practice. Her address is 14256 Ventura Blvd., Sherman Oaks, Calif. 91403.

W. Brewer Grant

The Patients nobody wants

Recent years have seen a revolution in care and treatment of the mentally ill. There have been new concepts of treatment, new definitions of the problems and changes in the roles of those providing care and treatment. As in most revolutions, the past has been largely repudiated in the rush of enthusiasm for the present and the future.

Like all successful revolutions, this has brought about many necessary changes and considerable progress. It has also created an inevitable period of readjustment. We find a great deal of confusion, particularly with respect to the public sector, with which, historically, the responsibility for a major share of this problem has always rested.

If we look back a few years, we find that, for better or worse, the role of the state mental health department was fairly well understood. It may be said that the role was more often worse than better, but at least it was clear. Although state mental health departments tried to offer a range of services, depending upon available facilities and personnel, state institutions tended to become the "end of the line" for patients

with problems no one else could or would handle. A high percentage of the inpatients were geriatric, with all the problems of older persons, including senility. It has been estimated that the geriatric group made up 40 percent or more of the state hospital patient population. Another group of state hospital inmates was made up of those, who, for want of a better classification, might be referred to as "hard-core", multi-problem patients. These two groups made up substantially more than half of the patients in state hospitals.

Then, with improvements in medication, the opening of the wards, new therapeutic insights, volunteers on the wards, increased community interest, and other advances, many exciting things began to happen. There are innumerable examples of drastic improvements in entire wards and of patients who had spent twenty or thirty years in institutions returning home to families and friends.

These successes, however, should not blind us to the fact that there still remains a large group of hard-core, multi-problem people who have traditionally been the responsibility of state mental health departments. Many of these are geriatric, and it may be argued with great validity that they really do not belong in a hospital devoted to the care and treatment of the mentally

Mr. Grant is the executive director of the Mental Health Association of Greater Chicago, Inc., 407 South Dearborn St., Chicago, Ill. 60605. This article does not represent an official position of the Mental Health Association of Greater Chicago.

ill. Yet these oldsters cannot be "hung on the hickory limb" while community agencies debate about what should be done for them and by whom.

The non-geriatric, hard-core, multi-problem patients are not easy to describe. Each is distinctive, but all have some common denominators. First, the mental or emotional illnesses of these people have a high degree of chronicity. There may well have been periods of great improvement, but setbacks have frequently occurred. Chronicity itself does not necessarily create the hard-core patient, since many such persons, through counseling help, medication, self-help programs, and other means have been able to live reasonably well in the community.

The multi-problem patient compounds the chronicity of his mental or emotional difficulties with many other problems. Economic dependency is one common denominator of most of these patients. Then there may be physical problems, including deformities, educational deficiencies, social maladjustments—divorce, desertion, etc.—lack of families or relatives. In short, if there is a problem around, some of these people will have it.

As somewhat of an aside it should be observed that many of these multi-problem patients are highly visible. Visitors to a state hospital are most often impressed or depressed by their unusual appearance, dress, or actions, which in the minds of the uninitiated come to be thought of as characteristic of all the mentally ill.

It should be noted, too, that while some of these hard-core persons have had little opportunity for real treatment, others have had a great deal of attention from some of the best public and private agencies over a period of many years. It would seem reasonable to assume, furthermore, that a substantial percentage of the large group of "re-

volving door" patients who are regularly discharged only to return come from this hard-core group.

It is around these persons that a substantial part of the current confusion about who is responsible and much of the general citizen's concern about gaps in treatment for adults arises. The need for more services for children and adolescents rests apart from this situation.

The recognition of the existence of this great number of hard-core persons who have traditionally been the responsibility of the state system would seem to be basic to any realistic discussion of what should be done to improve care and treatment for them. Yet the mental health revolution seems to have created a tendency to make plans as if this hard-core group really didn't exist at all.

In Illinois an outstanding example of this latter point of view was the complete removal of the category of conditional discharge by the Illinois Department of Mental Health during the 1967 legislative session. Conditional discharge was an administrative method by which the treatment facility could, when it seemed advisable, formally maintain a continuing responsibility for the patient discharged to his family, a boarding or nursing home or other facility. As already implied it was an optional tool to be used only in such situations in which, according to the judgment of the person making the discharge, the best interests of the patient would be served.

Like most other tools, conditional discharge could on occasion be badly used. Nevertheless, it did seem to offer to many hard-core patients, their families, boarding or nursing homes a practical supportive tool which could at least be tried when almost no other alternatives were available.

For example, many discharged patients find continuing to take their medication a problem. They are discharged with medica-

tion. They continue to feel better. Their medicine runs out and it is too much trouble or too expensive to renew the prescription. After a while they begin to feel badly and back they go to the hospital. If some of these persons had someone who could at least say with authority: "You must take your medicine until the doctor tells you to give it up," their return to the hospital might be prevented.

There certainly could be little need for the use of conditional discharge in a situation where the patient has a good continuing relationship with his doctor or has a family, a job, and other supportive factors working with him after discharge. Unfortunately, the hard-core patient too often has few, and sometimes none, of these supportive factors.

This "wishing will make it so" attitude reflected in actions such as that on conditional discharge also permeates much of the discussion about community mental health. A typical description of the advantages of the community would be the following:

"It is here (the community) that factors crucial to recovery and rehabilitation are present—families, jobs, friends, familiar environment and increasingly professional assistance to administer treatment and aftercare."

As already pointed out, for most of the multi-problem, hard-core patients these positive factors in his or her community simply do not exist. In fact, unless there are sufficient services to engage in intensive counseling with families or relatives, merely discharging the patient back into the same unchanged family or community situation from which he came would seem to be of doubtful value in many cases. To further compound the problem it is important to observe that most of the communities that

receive the largest groups of discharges have the fewest available services, at least in large metropolitan areas.

The mental health association is behind the proposition that all communities need many more services not only for the mentally ill but to help citizens meet all kinds of social and health problems. At local, state and national levels associations devote a major part of their efforts to these objectives.

It would seem, however, that our dedication to creating a better system as rapidly as possible should not blind us to the realities of the hard and difficult transition period while this system is being created. We cannot as citizens demand miracles and we should certainly ask the professionals not to promise them to us. There has clearly been a tendency to oversell the new procedures and to try and equate any change either within the hospitals or in the community as somehow or other being therapeutic per se.

Although the total situation is extremely complex, one fact does seem to be clear: that is that where mental health departments traditionally have had the responsibility for the type of patients previously described they must continue to be held responsible for such patients until sound alternatives can be developed.

At the same time, it must be underlined that mental health associations and other public and private agencies have an obligation to work actively with departments of mental health to develop either better alternative sources of care for certain of these patients, or better programs for them under the direction of the department of mental health.

At the same time we must try harder to define as realistically as possible what type of services need to be developed for the hard-core persons. As one fairly simple example, geriatric patients in need of con-

siderable nursing care would seem to need more and better nursing homes. For those not needing nursing home care, definition of what should be provided is not easy since as previously mentioned many of these people have already had considerable time and attention from existing services with limited success.

In short, all of this may well mean that for the best interest of many of these persons some form of extended leave or conditional discharge may have to again be made available. Such a tool could not only give some supportive help in the community to the dischargée, but could assure prompt and responsible attention by the facility which made the discharge when the community caretaker needs that kind of help.

The types of services needed, like the types of patients involved, should probably be seen as a spectrum, with much of the stress on rehabilitation and supportive everyday help. A few examples would be the new day centers being planned by the Illinois Department of Mental Health; the rehabilitation programs conducted by the Illinois Department of Vocational Rehabilitation including Work Experience which is sponsored by the Mental Health Association of Greater Chicago; the Thresholds

day care activities; the halfway houses such as Roscoe Apartments sponsored by Elgin State Hospital; and the residential care homes which can, depending upon the services they offer, become sources of positive help for the patients or little more than state hospital wards transferred into the community. As suggested earlier, far more services for counseling parents and relatives also must be developed in the care system.

We may well have to face the fact that certain people in the hard-core group will need for a long time a type of continued supportive relationship with someone. This does not mean a long-term hospital ward stay with limited services; but neither is the answer as simple as some type of long-term stay in a poorly run community facility with perhaps even fewer services.

Having in our enthusiasm embraced the whole range of human behavior, we may, with humility, have to conclude that we do not have the answers for some of these multi-problem people. Recognition of this fact should not be regarded as an admission of failure. In fact, it might well lead us to face more realistically what we actually can do for these complex and difficult cases and who should be responsible for seeing that it is done.

James K. Whittaker, M.S.W.

Developing a unified theory of residential treatment

Introduction

Despite the success of Fritz Redl and David Wineman's classic, *The Aggressive Child*,¹ relatively few articles have appeared in the clinical literature describing the application of the "life space interview" and "behavior management" techniques developed by the authors at Pioneer House in Detroit in the late 1940s. The method consists of a series of interview strategies and behavior management techniques which are used to deal with the problems and "issues" that develop between a child and his physical and social environment; the primary locus of treatment rests not in individual psychotherapy, but in the child's own natural life milieu. The use of this model of intervention in a residential treatment center assumes that the persons closest to the child for the longest periods of time (the child care workers) will have the major impact on his pathology and thus should bear the major responsibility for his treatment. Thus, the child care worker becomes the life space therapist. All of the

human and physical resources of the residential treatment center are ordered in such a way as to produce a truly therapeutic environment which is both the primary means of treatment, as well as the context within which it takes place.

Yet the life space model of treatment has not been put into practice on any large scale; this is true in regards to the application of specific techniques, as well as in the development of treatment centers on the model of Pioneer House.

Factors in Lack of Utilization

I would suggest at least three probable reasons for this:

1. Despite Redl's great skill at classification, his terminology is sometimes "fuzzy." Terms such as: "hypodermic affection", "antiseptic bouncing", and "reality rub-in" are too folksy for the more scientifically minded mental health professional to accept. Coming as it did, at a time when the behavioral sciences were placing a great deal of emphasis on precision, quantification and simplicity in theory building, Redl's rich and sometimes "overripe" terminology was too much to take. Similarly, his frequent medical and technological analogs—"neglect edema in the land of plenty" and "new tool salesmanship"—to cite but two, frequently

A lecturer at the University of Minnesota School of Social Work, Mr. Whittaker was formerly the assistant director of The Walker Home for Children in Needham, Mass. Requests for reprints can be addressed to him at 2228 Carter Avenue, Apt. 3, St. Paul, Minn. 55108.

stagger the imagination. A close reading beyond the titles reveals that most of Redl's concepts are quite well defined and are usually accompanied by one or more examples of the phenomena he is describing. What seems important is that one accept or reject the life space interview strategy on the basis of its utility, rather than on its labels.

2. A second major factor in the rather limited use of the life space model of treatment has to do with the connotations of an overly "permissive" environment which the book and some articles have conveyed to a portion of readers. This is due in part to the type of children Redl chose to treat. Aggressive and acting out, many of these children were well on their way to becoming sociologically trained delinquents: clearly not the type of youngster usually dealt with in an open setting. Though Redl himself views "permissiveness" as possible only within certain boundaries² and has written in detail of the false dichotomy between "permissiveness" and punishment—as well as on the value of rules, structure and routines—many have understood "permissiveness" to be a synonym for license. The most unfortunate aspect of this viewpoint is that it often rejects the entire model because of a criticism of what is perceived to be the underlying philosophy. This appears inconsistent, since one need not accept the model in its entirety. This is the problem with the way in which current models of treatment are used in residential settings; typically, the treatment of choice most commonly used in an institution marks the treatment center as "that type" of program, to the exclusion of other modalities. What is needed, is an overall theoretical framework for milieu treatment that has room for life space treatment techniques, as well as those of traditional psychotherapy and some of the newer in-

novations in the clinical application of socio-behavioral learning theories.³

3. A third and perhaps most plausible explanation why relatively few applications of the life space model of treatment have been made, has to do with the structure within which institutional facilities for emotionally disturbed children have traditionally been established in this country. It is fair to say that many, if not most, residential facilities are organized more around the needs of the professional groups who run them than around the needs of the children they purport to serve. Thus, we have a "medical model" of residential treatment which is usually just an extension of the psychiatric team from child guidance. In this system child care workers are used to care for and often live with the children, but their function is not usually seen as much as "treatment", as it is to provide a safe, benign and hygienic environment for the child between psychotherapy sessions. A variation on the medical model is the "social work" model of residential treatment. Here the same kind of role rigidity is maintained despite a shift in the status hierarchy. Typically, psychiatric social workers are responsible for the treatment of the children—usually office interviews—though they may make use of psychiatric and psychological consultants. In recent years the elevation of so many specialties to professional status has in some ways served to the detriment rather than to the benefit of the children in care. For example, in the course of a single week's time the disturbed child might be expected to see his psychotherapist, group therapist, family caseworker, occupational therapist, recreational therapist, music therapist—and so on. The implicit assumption, of course, is that each specialist brings his particular knowledge and skill to bear on the child's problem in such a way as to

produce a single, lasting treatment effect. The difficulty is that children usually do not come to treatment with such neatly encapsulated and "well defined" problems. In addition, such a model provides little flexibility in that what is actually accomplished has more to do with the particular area of competence of the specialist than with the needs of the individual child.

The life space model of treatment eschews such specific role definitions and adopts a far more generic approach. It is a model of treatment developed from the problems posed by the children in care and not from the needs of any single professional group. Herein probably lies a major source of the reason why the model has been adopted so infrequently: it wreaks havoc with the traditional notions of "who does what" in a residential treatment center. In addition, the life space model contains a built-in threat to the therapist used to working only in the sanctity of his office and within the context of the 50-minute hour. Dealing with problems in the life space is akin to working in a fish bowl: both successes and failures are clearly visible to all. It has been the experience of this writer, however, that nothing serves to strengthen the relationship between child care worker and therapist more than the sight of the professional groping to find a way to manage a child with whom the child care worker has been having difficulty for an entire morning. Children also seem to perceive that adults really do work together and there are many fewer attempts to play one staff member off against another.

Summary

From its beginnings, residential treatment has been operating on a patchwork of theoretical remnants borrowed from child guidance practice, traditional psychother-

apy, social group work and special education. The actual practices and standards of evaluation for residential treatment have had more to do with the needs and requirements of the mental health professionals than with the needs of the children such settings were designed to serve. Most so-called "therapeutic milieus" (and who would admit to having anything else?), pay lip service to the value of life space therapy, while still placing primary responsibility for treatment in the 50-minute hour. It would seem time that those professionals interested and involved in residential treatment begin to develop models of intervention that would eventuate in a unified theory base for residential therapy. I would suggest the following criteria for this theoretical framework:

1. That it be developed from the needs and requirements of the children in care and not from the needs of any professional group.

2. That we ask, "What needs to be done in a truly therapeutic milieu?", rather than start with a preconceived notion of what persons are eligible to perform certain tasks.

3. That this theoretical framework be broad enough to incorporate current and future innovations and not be limited to a single point of view. It is clear by now that the models of residential treatment that will survive will be those that are self consciously eclectic and flexible enough to adopt new strategies and techniques as they are developed.

The urgency of this task of theory building is paramount. New methods of treating emotionally disturbed children are being developed in other areas—particularly in the community mental health movement—and it is imperative for those who believe that residential treatment still serves a vital purpose in the total mental health picture to specify just what that purpose is.

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RECOMMENDED READING

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The International Association of Workers for Maladjusted Children will hold its Seventh General Congress in Versailles, France from the 6th to the 10th of July, 1970. The theme will be The Social Role of the Specialized Educateur for Maladjusted Children. For further information, write to M. Henri Joubrel, president of the Association, at 66, Chaussee d'Antin, 75 Paris 9°.

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Looking Back

Recently we received a letter from Sister Anne Cawley, O.S.B., a psychology professor at Mount St. Scholastica College in Atchison, Kansas, calling our attention to some articles written by a psychiatrist more than 120 years ago. She uses them in her courses to disprove the impression one often receives that "practically everything worthwhile in therapeutic mental health procedures has been discovered since 1940." In 1848 the ideas of moral treatment of the insane had been carried over from Europe and were in practice in many parts of this country. As is pointed out in other articles in this issue, many of these theories are enjoying a renaissance, and parallels can be drawn between the era of moral treatment and the community mental health movement. We are happy to print some excerpts from The United States Catholic Magazine and Monthly Review of 1847 and 1848. The articles from which these were drawn were written by William H. Stokes, M.D., of the Mount Hope hospital, now known as Seton Hall Institute near Baltimore. They are from the fourth and fifth annual reports of the institution.—THE EDITOR

This institution, owned and conducted by the Sisters of Charity, is located in the immediate vicinity of Baltimore. It is of recent origin, and is devoted principally to the reception of the insane. In its construction and arrangement, special reference has been had to the restoration of persons laboring under disordered mind. . . . From the commencement the principle has been fully recognized here and carried into effect, of constructing the buildings and arranging the adjoining grounds exclusively with a view to the greatest good to the patient. Thus will the first impression made on the patient, as he approaches his new abode, be of an agreeable character.

Approaching their new home, as they do, with their minds full of apprehension and distrust—ready to torture the slightest unpleasant circumstance into an augury of evil—it is doubly necessary that nothing, either in the interior or exterior arrangements, should meet their sight calculated to disturb their feelings or to strengthen their delusions.

In reference to the interior arrangements, we may observe that the parlors, reception rooms, and sitting rooms, are large and spacious; and to relieve the nakedness of the walls, and render them more attractive to the patient, they are furnished with paintings, cases filled with curiosities, specimens of shells, minerals, and other objects of interest. Nothing has a more salutary effect upon the insane than to inspire them with an interest in persons and things around them.

As regards our moral treatment of the insane, our whole system may be summed up in two words, kindness and employment. That a spirit of kindness and benevolence pervades this institution, no one can doubt who is acquainted with the Sisters of Charity. . . . However gorgeous and imposing may be the architectural embellishments of its buildings—whatever the ability, zeal and activity of the physician—it is at last, on the character of the attendants that must mainly depend almost everything relating to the moral management of the patient, as well as his general comfort and well-being. Unless they are humane, cheerful, good-natured, and capable of entering heartily into the views of the physician, the patient will necessarily be deprived of most important aids to his recovery. How is it to be expected that the uneducated

hirelings, who, for the most part, enlist in this service in most institutions, can possess these essential endowments of the mind and heart? . . .

Kindness and employment, as we have said, constitute the fundamental elements in the moral treatment of the insane. The high importance of supplying occupation to our patients, we trust and believe, is duly appreciated in this institution. We resort to it the moment their condition will admit of it, and they can be induced to engage in it. In the management of the various forms of *partial insanity particularly*, we place great confidence upon the use of such means of occupation as are calculated to detach the attention of the patient from the subject upon which he has morbidly fixed it, and to engage it with other objects of interest and importance. . . .

We generally experience very little difficulty in prevailing on our patients to engage in some healthful occupation. Example, which has so great power over the opinions and actions of men, also exerts a very potent influence over the insane. Indeed, so deeply rooted is this principle in our nature, and so strong and enduring the force of habit, that if we do but rightly and dexterously touch these inborn springs of action, we can experience no difficulty in obtaining a compliance with our wishes. . . .

A notion still prevails very generally in society, that insanity consists exclusively in a disordered condition of the mind—that it is dependent upon a perverted state of the immaterial principle of our nature, and that physical disorder has neither agency in producing, nor direct connection with the mental derangement. . . . This popular belief, it cannot fail to be perceived, begets of necessity a want of confidence in the efficacy of medical and moral treatment. Hence it too often happens, that, unless the mental affection breaks forth with considerable violence and turbulence, the period in which the disease can be most readily eradicated is allowed to pass unimproved, and in the majority of cases, incurable insanity is entailed on the unhappy individual for life. . . . Can anyone doubt, if the public could be generally impressed with these incontestable truths, that the mental disorder is in all cases connected with physical disorder, or at least co-exists with it and is aggravated by it—that, in the great majority of cases, the former subsides as the latter is removed, and, that this is most easy of accomplishment, in proportion as it is early submitted to treatment, can anyone doubt that the early stage would receive the promptest attention? . . .

But by the foregoing remarks, we would not be understood to speak in disparagement of moral means in the treatment of the insane. No one can entertain a higher estimate than we do of their curative power and influence. But we would not limit the resources embraced under the head of **moral treatment** to mere means of amusement, occupation, and the usual arrangements for employing, diverting or enlisting the attention of the lunatic. In an establishment for the insane, every regulation, every action, the spirit of every remark, almost every look may be invested with remedial power, or be pregnant with mischief. High as we regard medical treatment, we still feel satisfied that kind looks, and little acts of attention, denoting a real sympathy for them, are often more efficacious than medical prescriptions. . . .

In conclusion, we would briefly allude to the number of indigent patients, who are enjoying the benefits of this institution, and living on its bounty, without being able to make any compensation in return. The claims of the insane poor particularly, on their happier fellow men, are many and sacred. When the malady of the mind attacks the rich, abundant comforts, and all the resources that medical skill can command, are ever at hand: but let this blight fall upon the poor, in what consummate misery and wretchedness does it involve them? They are then doubly doomed—doomed to all the privations incident to poverty, and doomed to the loss of those high and noble faculties, which their God had given them, to enable them to provide against the casualties of life. We call therefore upon our Christian friends with earnestness and confidence, and with the assured hope that they will sustain and strengthen our hands in continuing and extending this noble charity.

J. Sanbourne Bockoven, M.D.

Community Mental Health: a New Search for Social Orientation

The author points out historical parallels between the inspired humanism of the moral treatment era and today. One of the shortcomings of that era was the failure to recognize the existence of interdependence among social institutions and human groupings. It is suggested that the community mental health movement will suffer the same fate unless there exist a network of adequate community services in all areas and an effective community administrative body to serve as liaison.

American Psychiatry: Inspired Humanism

The most unique and perhaps the black sheep of medical specialties is psychiatry. It was the first to form an organization of its own which, from the beginning, was completely independent from the American Medical Association. Psychiatry is also unique on two other scores: it cannot legitimately export specific practices developed in America to underdeveloped nations because it deals with the problems of individualities in relation to cultural attitudes of their own people and it did not originate in response to the demands of patients but from the demands of society for its own protection.

Dr. Bockoven is superintendent of the Dr. Harry C. Solomon Mental Health Center, 391 Varnum Ave., Lowell, Mass. 08154.

This paper is adapted from a speech made at the Massachusetts Conference on Social Welfare, December 5, 1968 in Boston, Mass.

In view of this, it is of considerable significance that American psychiatry, in the words of Dr. Gregory Zilboorg, "was from its very origin characterized by its inspired humanism."

Inspired Humanism: Initial Success and Then Failure

Thus, in the early decades of its moral treatment phase the American mental hospital was most effective in bringing relief to the mentally ill. Indeed, the discharge rates of the 1820s, 30s, 40s, and 50s, were fully on a par with those of our most advanced mental hospitals today. After the Civil War the effectiveness of these self-same hospitals not only declined to the zero point, but deteriorated even in their humanistic aspects to a degree which actually impeded the healing powers of nature and almost eliminated recovery as a possibility.

Something may have been lacking in the perspective of the leaders of the moral treatment movement of our early psychiatric history. Or perhaps, unforeseeable social changes of a destructive nature took place which brought the moral treatment movement to a halt. Studies which have been made of the entire history of the periods in question indicate that both explanations have some validity. It would seem reasonable to suggest that whatever it was that was missing in relation to the fate of the mentally ill, must have had a close relationship to shortcomings in the social leadership of that period which failed to prevent the Civil War and its accompanying damage to American society.

... our present mental health endeavors could undergo deterioration and end in much the same kind of failure that overtook the moral treatment movement after the Civil War.

More detailed study of that period suggests that one shortcoming in the social attitude was failure of the dominant ethnic group to extend its great respect for human individuality to members of other groups. Immigrants from Europe of different race and religion and black Americans were not accorded individualized treatment in mental hospitals. It is not likely that they were given greater consideration by other social institutions. Another shortcoming appears to have been a marked tendency to ignore the very existence of interdependence among social institutions and human groupings of all kinds.

Historical Parallels

The relevance of the foregoing to present concerns lies in there being a degree of similarity between today's community mental

health center movement and the moral treatment movement of the early 19th Century. There are other similarities. For example, the progressive liberal spirit of the Jacksonian Era is credited historically with the rise of the common man and is in other respect similar to the past two or three decades of our present era of increasing social welfare and civil rights' legislation. Both eras are likewise similar in regard to the presence of widespread social unrest and in regard to the occurrence of unpopular war; namely, the Mexican War of the 1840s and the Vietnam War of our 1960s.

To point out the likenesses of these two periods of history is to suggest that there may be more than the possibility that our present mental health endeavors could undergo deterioration and end in much the same kind of failure that overtook the moral treatment movement after the Civil War.

Social Orientation: A Striving of Democratic Peoples—Not a Matter of Health

Public support for mental health movements, including that of moral treatment can be seen as an expression of an unarticulated but fundamental striving of democratic peoples for social orientation which asserts itself most forcibly when the pace of social change is such that relative disorientation results. Democratic peoples could not survive without social orientation, for it is indispensable for them to govern themselves successfully. The kinship between the anxiety of disorientation and the idea of mental illness in the public mind may be proposed as one reason underlying the emergence of public support for mental health movements during the times of rapid social change. The difficulty lies in the fact that social orientation is not something that mental health services can provide. They

should not, moreover, be expected to provide it, since it is not a matter of sickness and health but a matter of social leadership. Indeed, mental health agencies are in search of social orientation themselves.

Perhaps it is not too rash to suggest that this may be the first time in the history of our great American experiment that the entire populace in all walks of life have come to believe that their troubles and miseries are the result of problems which can be solved by application of scientific knowledge already at hand or which scientific research will make available in the near future. This belief is also quite naturally accompanied by expectations, and then by demands for rapid solutions to problems in varying fields. Federally sponsored programs have done much to foster such beliefs, expectations and demands. These programs have also included efforts to bring about the direct participation of citizens in the planning of programs in their capacity as consumers of social, health and other public services.

We live in an era in which large scale remedial action is set in motion by big government and private philanthropy to correct social evils as rapidly as they can be brought to light. However, our best intentioned efforts must somehow be going askew, for this selfsame era is even more conspicuous for its mounting volume of open conflict, contentiousness, protestation, and dissention. There are, however, also signs of a desire detectable in practically all quarters for rapport and collaboration.

The Mental Health Endeavor and Avoidance of False Hope

The observation that our quickened pace of social progress is accompanied by even greater social unrest is a matter of some interest, especially when placed alongside

the observation that the mental health movement has for several years now enjoyed strong support and relative tranquility. One may speculate that this is so because the mental health agency may occupy a special position in public fantasy as being neutral territory, free of prejudice, where humanistic acceptance prevails and where something called empathy is offered to desperate and troubled people. Thus, the most important task facing the mental health establishment may be that of reassessing its position both as a symbol and as a basis of new hope for resolution of conflicts threatening social solidarity.

Such an attitude could be as socially divisive as the witchcraft period of our early history.

There is much work to be done in gathering and interpreting vast amounts of data. One thing that can be said at present is that mental health occupies a position of great potential for truly enormous embarrassment if more groups feel encouraged to end their search for social orientation with the idea that mental health can provide what is missing at about the same time that mental health itself becomes aware of its pressing need to become socially oriented in its own behalf. To avoid the disaster of such embarrassment, it behooves the mental health agency to acknowledge that it is in the same boat with other groups and seek to join forces with them in making a common inventory of the social realities of American life today.

It is suggested that the crucial problems of our time for the individual, for the group, for the community, and for the entire society, may be fruitfully explored as being a problem of social orientation. This problem in its present magnitude is a newcomer of relatively recent origin which has

insidiously crept into the American social scene. Its existence is largely due to the preposterous situation that new knowledge and new techniques are being produced much, much faster than they can be absorbed.

Misplaced Priorities: A Source of Social Disorientation

We must consider what the priorities may be that we hold to, which may be related to social disorientation. It is probably fair to say that the highest priorities in American life are granted in terms of both time and money to activities related to formal education, transportation and entertainment. Relatively very little time or money is spent in small group activities in which sufficient continuity of relationship is sustained long enough to result in more than superficial acquaintanceship. It would appear that modern industrial life has taught us to value ideas more highly than people and to work harder to acquire knowledge of authoritative facts and scientific abstractions than of the individuality of those whose lives bear a relation of interdependence to our own.

Neglect of the fact of the uniqueness of human individuality may well be an important source of the problems we face. In relation to community mental health, this is a crucial issue, for mental health in itself defies definition. This is inescapable, since the uniqueness of the human individual extends to the point of requiring that each person be classified as one of a kind chemically, physiologically, anatomically, and psychologically. We must admit that his uniqueness is a nuisance which denies us certain knowledge whether such a thing as mental illness actually exists or not. There is the ever present possibility that it is merely a label which one variety of unique

people who happen to be in the majority apply to other varieties who happen to be in the minority. We should admit that our knowledge in this area is very limited and that many possibilities remain to be considered.

Considerations such as these could well be borne in mind in developing community mental health programs, especially in regard to preventive efforts based on case finding of incipient mental illness. It may never be possible to distinguish between the latter and a developmental phase of a particular unique individuality.

The mental illnesses on the one hand and the social problems of individuals on the other can profitably be regarded as forms

... those of us who say, "You can't fight city hall" will not hesitate to fight the federal government ...

of decompensation of morale and competence which vary in frequency, severity and duration in correlation with the level of socio-political maturity of the society to which the individual belongs. It may well be that community mental health is most effectively secured by community leadership which assumes responsibility for programs to raise the level of the community's socio-political maturity. Such programs would be aimed at increasing sensitivity to the individuality of its citizens and making judicious provisions to meet their social needs as persons. The mental health center or hospital would then receive as patients only those individuals who have not responded to the best possible community efforts and who are incapacitated by a degree of psychopathology actually demanding study and treatment by psychiatric specialists.

A Case For the Role of Local Government

Our concern regarding social orientation leads us in the direction of making a case for the role of local government in meeting the psychosocial needs of citizens for adequate orientation to their society and in meeting the needs of the public servants of organized society to be adequately oriented toward recognition of the uniqueness of the individuality of each citizen. There is much to commend this view, for it may be more realistic and more conducive to social solidarity than permeating the community with mental health programs to seek out early cases of mental illness. The latter course of action might tend to foster a social attitude of suspiciousness of every act of non-conformity as being a tell-tale symptom of sickness of the mind. Such an attitude could be as socially divisive as the witchcraft period of our early history and could in no case be appropriate for sponsorship by government.

Government is always an art irrespective of the ideology behind it and humanistic government is an art based on the humanist's affection for men and women in all their diversity. It is fair to say that the American people, in their practice of this art at the federal and state levels, have successfully propagated pluralistic solutions to socio-political problems in a manner which respects the fact of human diversity. They have also been successful thus far in limiting monistic developments to short-lived experimental application.

The glaring exception to this record of achievement is the American people's neglect of government at the local community level. There is little to be recognized in the modern history of city, town, or county government which would warrant classifying it as an art based on humanistic affection for people. Indeed, the main reason

for federal legislation providing community poverty programs, model cities programs, and community mental health centers throughout America is to meet the needs which local government has been unable to meet. These measures, however, do not go much beyond providing temporary symptomatic relief. Relatively few results have become visible from efforts made to identify and correct underlying social defects. Perhaps the origin of some of these defects is to be found in the early history of our local communities. I refer to the fact that in Massachusetts most, if not all, towns were governed by their local church organizations for many decades. May it not be that a power vacuum developed in our cities and towns with the constitutional separation of church and state and the decline of church influence in later years? Is it not probable, furthermore, that this power vacuum would come to be filled by persons less endowed than their clerical predecessors in regard to sense of duty and stewardship to their community? Whatever the answer to these questions may be, it is plain that local government today is faced with an array of pressing human needs which it is almost wholly unprepared to meet. Local citizens, moreover, do not appear to expect local government to reflect the American political heritage. In fact, those of us who say, "You can't fight city hall" will not hesitate to fight the federal government by putting pressure on our congressmen.

Renewed Local Government: A Key to Progress?

None of us can afford to let our courage fail us in learning and facing up to the facts of the social reality of our day. Some of these facts are longstanding truisms but somehow remain outside our field of attention; namely, that poverty, social conflict,

civil disorder, delinquency, crime, emotional disturbances and retardation of children, mental breakdowns of adults, and long-term mental disability are all afflictions which have their origin and development in local communities. Is it not incongruous that local government is almost completely devoid of the resources needed to deal with these problems?

The principal we need to invoke is that no authority can reasonably be expected to meet the needs of those for whom it is responsible when that authority itself is half-starved and just barely able to assure its own survival. The urgency of the situation demands that full attention be given to the coincidence, if it is such, that America's state hospital system and its system of local government have both shown themselves to be socially, as well as financially, bankrupt at a time when society as a whole needs each of them for guidance more than ever before.

New Opportunity Ahead: Three Programs Needed

There is simultaneous growth of support in favor of fundamental changes both in local government and in state mental health services. Thus, there is reason to look forward to increasing opportunity for vitally important new measures to be instituted in the near future. It is imperative that full use be made of this prospective period of opportunity.

Three separate endeavors suggest themselves on the basis of our experience thus far which require the joint efforts of mental health professionals and local governmental authorities.

1. Provision of new measures by local government to meet the needs of each citizen for information, guidance, advice, socialization, recreation, training and edu-

cation, in a way which takes into account his individuality and personal situation so that his personality assets will have all possible opportunity to develop to fullest capacity. This endeavor would be the responsibility of citizen organizations, political leaders and of educators, lawyers, psychologists, and social scientists.

2. Provision by local government of a full range of facilities within the community itself which will meet the needs of citizens afflicted with long-term mental disabilities. These facilities would be designed to provide each disabled citizen an individualized rehabilitation program which would include the necessary variety of occupational, recreational and residential settings. Other facilities would be designed to provide similar settings on a lifelong basis, and shelter as required, for those individuals for whom rehabilitation goals may be unrealistic. Mental health professionals would serve as consultants to this type of endeavor but would not administer the programs.

3. Provision by local government of facilities for prompt treatment of individuals afflicted with acute mental illnesses. These facilities would probably function best as psychiatric units of general hospitals.

A Mental Health Center in Action: Two Years of Exploration

The Dr. Harry C. Solomon Mental Health Center began its career serving the people of Greater Lowell in September of 1966. During the first several weeks, services were rendered under conditions of cheerful hardship—there being six offices, four desks, two telephones, and one card table for a staff of twenty. Calls began coming in during the first day. By the end of the month, 74 patients had come to the Center to keep appointments. By June 30, 1967, the end of the fiscal year, there had been 874 admis-

sions. During the two-year period following the opening of the Center, 2063 individuals were admitted to the Center. We have had two years of experience with the operation of Outpatient and Home Visit Services and a year and a half of experience with the operation of a 40-bed Inpatient Service and a Day Care Program, with attendance running as high as 70 a week. There have been nearly 600 admissions to the Inpatient Service and 250 admissions to the Day Care Program. In addition to these, there have been about 1100 patients admitted to the Adult Outpatient Service and another 600 to the Child Psychiatry Outpatient Service.

A number of experiences have been acquired during this two-year period of clinical and administrative work which may leave some lasting impressions. The most impressive of these has been the opportunity to observe a large majority of patients undergo marked improvement in but a few weeks with relatively little in the way of formal treatment beyond pharmaceutical prescriptions and with a great deal in the way of informal personal attention and effort provided patients by everyone employed at the Center.

This occurrence of marked improvement should not, however, be attributed entirely to treatment efforts made at the Center. There is much to suggest that ameliorative forces of considerable effectiveness have arisen spontaneously within the community due to the quality of human interest generated in this particular community by locating the entire treatment of the patient in its midst. At any rate, positive forces must be at work in this community in view of the fact that of some 600 admissions to the Inpatient Service, less than a dozen have required continuous hospitalization since admission.

These experiences bring up the important matter of the uniqueness of each com-

munity and of the great need each community has for a person or perhaps a task force of persons to develop approaches to meaningful comprehension of the inner workings of the community. Study is needed in terms of scheduled formal activities and in terms of spontaneous informal activities as well.

... the community mental health center may have the effect of reducing rather than increasing the tranquility of community life ...

Relative to this, we should be reminded that American psychiatric practices, as they have evolved in recent decades, are not suitable for application in most communities in the United States. Study is needed of each community to determine what the most suitable psychiatric approach might be as one element in the entire spectrum of community services already in existence or to be provided in the future.

The New Psychiatry: Its Arousal of Old Social Problems

The observation that marked improvement is the rule following admission to the community mental health center has another side to it which is of great public importance. I refer to what may properly be called social relapses, since they may be without recurrence of mental illness, or are accompanied by mild symptoms only reminiscent of the original illness. The exact number of such ex-patients is not yet known, but there is evidence that a fair proportion undergo loss of morale and personality regression, and settle into varying states of social dependency.

The occurrence of social dependency following mental illness is to be matched by another observation; namely, that it is not

at all unlikely that our services as a community mental health center have the effect of arousing socially quiescent individuals and stirring them to greater activity, some of which may add to the diversity of community life but which may or may not lead to filling a satisfactory social role. It would appear that the community mental health center may have the effect of reducing rather than increasing the tranquility of community life and of increasing rather than decreasing its overall social burden.

It would seem equally apparent, moreover, that the community mental health center could never meet the full array of

emotional deprivation and personality underdevelopment of any community. It needs a close, ongoing, working relationship with those who carry administrative responsibility for the community as a whole. In the absence of a community administrative body adequately staffed and equipped to serve its citizens, it is not likely that the community mental health center will be able to contribute much within the framework of its particular area of competence. It is more likely that the community mental health center will find itself immersed in case finding of social need and protesting the absence of community resources.

Book Reviews

Henry A. Davidson, M.D.

The Law and the Mentally III

Mental Impairment and Legal Incompetency

By R. C. Allen, E. Z. Ferster, and Henry Weihofen

Englewood Cliffs, N. J., Prentice-Hall, 1968. 401 pp.; \$29.95

The Mentally Abnormal Offender

Edited by A. V. deReuck and Ruth Porter

Boston, Little, Brown, 1968. 260 pp.; \$10

Orthopsychiatry and the Law

Edited by Morton Levitt and Ben Rubenstein

Detroit, Wayne State University Press, 1968. 255 pp.; \$4.95 (paperback)

Mental hygiene, as a discipline, is surely one of the behavior sciences—or, if “science” seems too strong a word, let us say that mental hygiene concerns itself with human behavior. And, in a way, so does law. It is not surprising that these two areas have an extensive overlap, generally categorized under such headings as “forensic psychiatry” or “psychiatric jurisprudence.”

Popularly, the overlap would seem to be

Dr. Davidson, former editor of MENTAL HYGIENE, is now in private practice. His address is 276 Prospect St., East Orange, N. J. 07017

Psychiatric Emergencies And the Law

By F. E. Kenyon

Baltimore, Md., Williams & Wilkins, 1968, 137 pp.; \$7.50

Hospitalization and Discharge of the Mentally III

By Ronald S. Rock, M. A. Jacobson, and Richard M. Janopol

Chicago, University of Chicago Press (for the American Bar Foundation), 1968. 268 pp.; \$10.00

in the area of criminal responsibility, in which a verbal battle is dramatized between psychiatrists and psychologists for the defense, who say that the defendant did not know what he was doing when he stomped on his mother-in-law, and the equally learned experts for the prosecution, who say that he knew what he was doing all right, but he just didn't care.

Actually, there is more testimony by psychiatrists and psychologists in the civil courts than in the criminal. Consider, for instance, the Allen-Ferster-Weihofen book

on legal incompetency. Here, in what must surely be the largest book on the subject, three attorneys report on an NIMH-sponsored project conducted by George Washington University. This text reviews the effect of hospitalization on competency and guardianship. There is a chapter on the role of the Veterans Administration and the Social Security Administration. Reported in some detail are legal problems related to marriage, property control, management of benefits, drivers' licenses, and selection of guardians. The authors discuss the competency problems of alcoholism, mental retardation, and senility. A historical review offers a solid understanding of the roots of these concepts in Anglo-American law. The material is salted with many case reports and authenticated by citations to decisions and to the literature.

Most of the books and articles on forensic psychiatry cluster around problems of criminal responsibility. As a consequence, little attention is paid to the civil side of the mental incompetency docket. And in that field, here is a veritable one-volume encyclopedia.

By contrast, the book edited by deRueck and Porter concentrates on the offender. It is a transcript of papers given at a Ciba Foundation colloquium on the mentally abnormal offender. Four of the essayists (Bittner, Diamond, Goldstein, and Watson) were American. The remaining 18 were British or Scandinavian plus one each from Belgium, Bulgaria, and the Netherlands. The formal papers were followed by informal discussion, most of which is here recorded verbatim.

One gets a somewhat discouraging impression from a reading of the entire symposium. It is easy enough to calculate statistically the chance that a catatonic, a defective, a manic, or an obsessive-compulsive will commit a crime next year. But

this doesn't help us when we have to decide whether to release a specific patient at a particular time. If statistics indicate that there is a 90 per cent likelihood of his committing another violent crime, should we keep him locked up because that probability is too high? But if the chances are ten to one that he will *not* engage in violence, would it still be safe to release him, knowing that the one chance in ten might explode any day?

Although the book offers no easy answers, it provides a thoughtful, often a wise, approach to its problem, and is well worth the attention, thought, and self-communion of anyone with responsibility for decision-making in this field. For a century, those of us in the behavior sciences—especially psychiatrists, social workers, and psychologists—have implied that, if you turn over the offender to us, we have a better chance of remolding him than the prison guard has. It might be embarrassing if some government opened the doors to its prisons, invited us in, and said: "Gentlemen, these are all yours. Show us how."

In 1966, the American Orthopsychiatric Association held a seminar on orthopsychiatry and the law. The papers read there are bound into the paperback edited by Leviitt and Rubenstein. The field covered is not that of conventional forensic psychiatry. The word "law" as here used refers rather to our country's general sociocultural setting. There is, for example, much concern about the invasion of privacy—in a sense the invasion of the unconscious by clinical interviews, certain medications, and eavesdropping devices. One of the essays represents an incisive (sometimes almost funny) analysis of the "security" (police or investigational) mind at work. There is a discussion of methods of evaluating character that result in the

building up of a personnel file that may haunt a person all his life. One of the essayists speaks of the juvenile court and is saddened at our disenchantment with this agency—at the promise that was never fulfilled. There are also a sidelight on white-collar crime and a chapter on the possibility of moving the psychiatric team right into the court room. Though somewhat overpriced for a paperback (\$4.95), the book offers a potpourri of papers, some wise, some sententious, some obvious, and some witty.

Somewhat less satisfactory to American readers is Dr. Kenyon's text on psychiatric emergencies. The "law" referred to in the title of this book is the British Mental Health Act of 1959. Dr. Kenyon examines the way in which psychiatric emergencies are handled at an "observation ward" in London. The 1959 statute provided for informal acceptance of most patients, for integration of psychiatric receiving hospitals with general hospitals, and for shifting much of the responsibility for the care of mental patients to the local Hospital Authority. There was a prediction that the new and simplified procedure would flood the hospitals with criminals, but this did not happen. There were, however, an increase in the emergency admissions of alcoholics, psychopaths, and addicts, a decline in geriatric cases, and a surprising escalation in the number of patients (especially women) of "no fixed abode." The study is complete with many statistical tables, including chi squares. The text is heavy, and the emphasis is on the application of British law. The findings are offered statistically rather than in human terms.

The basic dilemma of mental hospitalization is how to preserve the right of the patient to his freedom without jeopardizing the welfare of the community, or with-

out robbing the patient of a chance of being effectively treated. *Hospitalization and Discharge of the Mentally Ill* is an in-depth study, sponsored by the American Bar Foundation, of how we go about resolving this dilemma. Here reviewed are the legal processes of compulsory hospitalization of mental patients and the ways in which they are discharged. The survey is limited to only seven states (California, Delaware, Georgia, Illinois, Kansas, Missouri, and Pennsylvania). Throughout the text, emphasis is not on the statutory legal procedure, but on the living realities of the process.

The dilemma of community protection v. patients' rights may be rephrased as the two prongs of psychiatric folklore: the fable that mental patients are all dangerous and the equally treacherous fable that patients can be readily railroaded into mental hospitals. There is even a third dichotomy here: should the commitment procedure be basically judicial or essentially medical? In a way, the question is almost meaningless, because, when it comes to locking someone up against his will, the courts simply must make the ultimate decision.

The book includes an interesting historical story, providing background on the development of commitment laws in the United States, followed by an operational account of how they work, regardless of how they are *supposed* to work.

The report frankly reviews the flaws in the judicial commitment procedure: the need for an "either-or" type of decision (either commitment or no commitment), emphasis on objective or concrete evidence, and the long legal tradition of adjudicating controversies. The authors recognize that a judicial tribunal is ill suited to testing the alternatives to commitment. One of the weaknesses in the present quasi-medi-

cal, quasi-judicial procedure is that commitment becomes, in effect, a life sentence, with the hospital having (in practice) complete control of when to release the patient. Welfare and social needs rather than medical facts are too often the determinants of releasing the patient.

The authors suggest that commitments be for a fixed maximum period, a patient being discharged at the end of that time unless the hospital persuasively certifies the need for extended hospitalization. Hospitals sometimes keep people longer than medically necessary because of the lack of any other place to send a patient needing close supervision. Then, there is the fear that the institution will be held

responsible if the patient becomes violent after release. Under the proposed automatic release plan, the hospital would not have to certify that the patient is cured. All the institution would have to do is to keep quiet when the "term" ends; the patient would then be discharged, with no legal (and, one hopes, no moral) responsibility being imposed on the hospital for the patient's subsequent behavior.

Limiting the study to only seven states necessarily imposes some restrictions on the validity of the conclusions. One does not know how different the procedures would be in the 43 other jurisdictions. However, within these limits, the report is sound, solid, and provocative.

Education as Therapy. Suggestions for Work with Neurologically Impaired Children

By Ruth Mallison

Seattle, Wash., *Special Child Publications*, 1968. 166 pp.; \$3.50 (paperback)

Special Education has come of age: a textbook is available, and this alone makes the writing of this book worthwhile. There is no doubt that Ruth Mallison's work will become an important instrument in educating the educators and will benefit the students. Yet, to quote: "I admit that I am fairly fussy about the way I teach anything." The author uses the word "fussy" to mean "exacting." The book itself at times suggests the synonyms "indistinct" and "inexact." What, for instance, is a neurologically impaired child? The generalization of this term leads to generalizations in approach: "An educational evaluation can usually be done effectively in one session." The author describes the items of educational evaluations step by step, an excellent

compendium not only for teachers, but also for social workers and mental health professionals. To do an evaluation in one session appears, however, to be an impossible task.

Why does a person who can evaluate and devise a program in one session "truthfully answer (to parents) that it is hardly possible for anyone to predict the future"? Then Miss Mallison says, "The educational therapist does not attempt to change a parent's feelings." After all the difficulties of getting a total history, why not? Or, again to quote, "The directions we want to use depend on our estimate of the child's personality"—at first glance, clear-cut, but actually vague.

Often there is too much preoccupation with a deaf child who must look at the speaker or who fails to comprehend language or who is taught phrases such as "I ride bike" or "I eat apple," methods that apply to not more than a few neurologically impaired children. And what about style? From the simple "The drawing is hung up"

to the many question marks that might imply, symbolically, the questionable worth of the work, the language disturbs.

Some questions show the author's basic concern. "What is the most important thing to teach this child?" Are we becoming too "gadget-addicted"? She warns of pushing a child too fast: "First one must have something to communicate, must have a sufficient vocabulary available before the finesse of pronunciation should become of concern." Or, "A circle is a pretty dull thing for a young child." She turns it into a ball or a balloon. The parents are admonished to place their children in social situations appropriate to their functioning, not to their age. "To play, he has to be able to interpret the situation, to recreate it in some manner and in some meaningful fashion."

The specific case descriptions, the approaches to particular children and their remedies for disabilities, make this book a joy for any professional. The list of "selected readings" is excellent.

Thus it appears that we are on the horns of a dilemma. The book is poorly written; the generalizations pose perils to the student, to whom the book presents the temptation of "quickie learning" and license-getting. The reader often gets lost because of vague generalizations. But the author deals with the child and his role in planning. She presents an educator's evaluation, and she assigns the professional educator the role she deserves. The educational therapists participate in the workup and in the treatment as professionals in their own rights, demonstrating the high value of their own therapy.

Ruth Mallison is to be congratulated, and encouraged to expand this volume into a much-needed, all-encompassing book on educational therapy.—DIETRICH W. HEYDER, M.D., F.A.P.A., Norfolk, Va.

Teen Conflicts: Readings in Family Life and Sex Education

Edited by E. N. Bachelor, R. J. Ehrlich, C. J. Harris, and R. M. White

Berkeley, Calif., Diablo Press, 1968. 240 pp.; \$1.95 (paperback)

There are 18 million youngsters between the ages of 13 and 17 years. Recent statistics show that half a million girls drop out of school around the age of 16, yet little effort is made to keep these girls in school. Only the parents of boy dropouts are generally called for interviews with school authorities; boys usually have program adjustments made for them, and exit interviews are sought. Still, it is known that girls are frequently better students than boys—dropouts, that is—and could complete high school. Furthermore, U. S. Department of Labor statistics show that girl dropouts have the highest unemployment rate in the nation. And there are a quarter of a million unwed mothers each year, 5,000 of them being under 15 years of age and 50,000 of them under 17. Something seems to be seriously wrong! One more startling statistic: the venereal disease rate is climbing, and most disastrously among the young and vulnerable—and ignorant—teenagers: 300,000 teenagers get venereal disease each year.

These facts are so shocking that most people concerned with teenagers are anxious to eliminate as much ignorance as possible and to give the youngsters whatever knowledge and advice are now available. This collection of articles from popular magazines and newspapers affords an excellent overview of some of the problems of growing up. Most are written simply, but with enough journalistic flair to make them hold one's interest. It is fortunate that the book

is a paperback: students can tuck it in a pocket and browse through it while riding the bus or subway to school.

This book would certainly be invaluable as a means of stimulating class discussions for home-room guidance, sex education, or family-life programs. There is no philos-

ophizing or moralizing—"just the facts"! The facts and figures are sufficiently dis-maying that even the youngest high school student can draw the appropriate conclusions about drugs, promiscuity, responsibility, and mature behavior.—LESLIE J. COWNE, Ed.D., New York, N. Y.

BOOKS RECEIVED

Because of space and time limitations, we cannot review all the books sent to this journal. The listing of such books in this column must be considered acknowledgment of the receipt of the volumes indicated. As space, time and subject matter permit, we will publish full-dress reviews of the more significant books in the areas of interest of our readers.

PRESENT CONDUCT AND FUTURE DELINQUENCY. By D. J. West. New York, International Universities Press, 1969. 207 pp.; \$8.50. This is a preliminary report of a kind of study that should be more common, what is called a prospective study, in the "trade". This book contains the baseline data on 400 boys, ages 8-9, who have been followed (in yet to be published studies) until the age of 16.

BEHAVIORAL THERAPY. By Schaefer and Martin. New York, The Blakiston Division, McGraw-Hill Book Company, Inc., 1969. 233 pp.; \$7.95. This book appears in both hardcover and paperback form and is one of the few book-length descriptions of the technique of modifying the behavior of institutionalized patients, with an emphasis upon the use of sub-professional personnel. Interesting and potentially valuable.

SCHIZOPHRENIA—CURRENT CONCEPTS AND RESEARCH. Edited by D. V. Siva Sankar, Ph.D. Hicksville, New York, PJD Publications Ltd., 1969. 944 pp.; \$21.50. This interesting volume, about the size of a telephone book of a moderate size city, is an offset reproduction of a conference held in late November of 1968 and laudably appears in print within a year of the meeting. As in every such collection, the contributions are highly variable, but it gives an interesting overview of many of the major emphases in this complex research field. Most of the papers are devoted to one or another of the biological aspects of the illness, and some contain data not easily available elsewhere. Essential for the researcher in schizophrenia.

PSYCHIATRY FOR SOCIAL WORKERS. By Alistair Munro, M.D., and Wallace McCulloch, M.Sc. Oxford, Pergamon Press Ltd., 1969. 276 pp.; \$6.50 hardcover, \$4.75 paperback. This "psychiatry" is quite a bit different from the psychiatry taught to social workers in this country; and consequently this little paperback might have a wider use in acquainting Americans in general with the elements of British thinking.

PSYCHIATRY FOR LAWYERS. By Andrew S. Watson, M.D. New York, International Universities Press, Inc., 1968. 326 pp.; \$10.00. Andy Watson is probably the most skillful and learned of the few psychiatrists working in a law school setting. This excellent book could be read with pleasure by lawyers, and even psychiatrists might read it with profit.

CLINICAL PSYCHOLOGY AS SCIENCE AND PROFESSION —A FORTY-YEAR ODYSSEY. By David Shakow. Chicago, Aldine Publishing Company, 1969. 350 pp.; \$12.50. David Shakow has been one of the major influences in the psychological study of, especially, psychosis. This collection of his papers should be read especially by the young, that they may find how depressingly acute and innovative their elders were.

THE SOCIOLOGY OF RESEARCH. By Gunnar Boalt. Carbondale and Edwardsville, Southern Illinois University Press, 1969. 16 pp.; \$5.95. This is a study in the sociology of sociology, and might be read with interest, and probably profit, by most research workers in human behavior.

THE PSYCHOLOGICAL IMPACT OF SCHOOL EXPERIENCE. By Patricia Minuchin, Barbara Biber, Edna Shapiro, Herbert Zimiles. New York, Basic Books, 1969. 521 pp.; \$12.50. This is a major research study done by the famous Bank Street College of Education of nine-year-old children in different kinds of schools.

MANPOWER FOR MENTAL HEALTH. Edited by Franklyn N. Arnhoff, Eli A. Rubinstein, and Joseph C. Speisman. Chicago, Aldine Publishing Company, 1969. 204 pp.; \$6.95. This little book contains some of the more challenging ideas about our current manpower deficits and possibilities. It should be looked at by anyone interested in the future of mental health.

THE AUTHORITARIAN PERSONALITY. By T. W. Adorno, Else Frenkel-Brunswik, Daniel J. Levinson, R. Nevitt Sanford. New York, W. W. Norton & Company, Inc., 1969. 990 pp.; paperback \$4.95. This major study of prejudice and the kind of personality that is apt to demonstrate it has been a major influence in our thinking since its appearance in 1950. It is now available to a new generation in paperback form, and should be part of the intellectual equipment of every worker in human behavior.

EDUCATING THE EMOTIONALLY DISTURBED, A Book of Readings. Edited by Hardwick W. Harshman. New York, Thomas Y. Crowell Company, 1969. 490 pp.; \$5.50. This rather expensive paperback brings together a number of readings that would be undoubtedly useful to those working with disturbed children in a classroom setting. The book does demonstrate rather too clearly our current approach to this problem, with excerpts that range from anecdotal to the well-designed, with probably more of the former than the latter.

AN EVALUATION OF THE RESULTS OF THE PSYCHOTHERAPIES. Edited by Stanley Lese. Springfield, Ill. Charles C Thomas, 1968. 351 pp.; \$12.00. This is a collection of interesting papers that report various projects in evaluating psychotherapy.

THE RETURN HOME. A STUDY OF THE EFFECTS OF CHEMOTHERAPY ON RELEASED PSYCHIATRIC PATIENTS. By Robert V. Heckel, Arless J. Epps, Charles W. Perry, and P. G. Reeves, Jr. Columbia, S. C., South Carolina State Hospital, 1967. 81 pp.; gratis (paperback). A long-term study of the effects of psychoactive drugs on post-hospital behavior. (Copies should be requested from Dr. Robert V. Heckel, Director of Clinical Training, Psychology Dept., University of South Carolina, Columbia, S. C. 29208.)

COMMUNITY LIFE FOR THE MENTALLY ILL—An Alternative to Institutional Care. By George W. Fairweather, David H. Sanders, David L. Cressler, and Hugo Maynard. Chicago, Illinois, Aldine Publishing Company, 1969. 357 pp.; \$10.00. An interesting study of an extremely important topic—whether psychotics can maintain themselves in the community-at-large. This moderately optimistic book demands careful study.

THE CHILD—A Book of Readings. By Jerome M. Seidman. New York, Holt, Rinehart and Winston, Inc., 1969. 692 pp.; \$6.95 paperback. A large and expensive paperback, containing an interesting mixture of articles concerning child development and socialization; probably useful as an ancillary text.

INTERDISCIPLINARY RELATIONSHIPS IN THE SOCIAL SCIENCES. Edited by Muzafer Sherif and Carolyn W. Sherif. Chicago, Aldine, 1969. 360 pp.; \$9.75. There are some interesting articles in this collection, but its relevance to our particular problems are not as close as they might be.

I'M GLAD I WAS ANALYSED. By Petronella Fox. Elmsford, N. Y., Pergamon Press, 1968. 141 pp.; \$5.50 (hardback), \$4.00 (flexicover). Another in what is now a genre: the revelations of an analysand.

NEVER COME EARLY. By Joseph J. Partyka. Mountain View, Calif., J. Partyka, 1968. 193 pp.; \$5.95. Revelations of a patient.

LETTERS TO THE EDITOR

MENTAL HYGIENE encourages discussion of articles which appear in it. Letters to the Editor should be typed, double-spaced, preferably 150 to 200 words in length. The writer's name, professional affiliation if any and address should appear at the end.

TO THE EDITOR:

Congratulations to MENTAL HYGIENE for presenting the most cogent critique of Jensen's position that has yet appeared (Golden, M. & Bridger, W.: A Refutation of Jensen's Position on Intelligence, Race, Social Class, and Heredity, MENTAL HYGIENE, 53:648-654, 1969). Prior criticism has tended to be of three types: a) I.Q. tests are not valid measures of educational functioning; b) that evidence is still insufficient to make judgments about intergroup differences; c) emotion-laden appeals to the reader to reject Jensen's views because they are racist. All of these miss the mark and leave Jensen's basic points unrefuted. What Golden and Bridger have done is to demonstrate that Jensen has misused statistics to support his conclusions. I am reminded of the canard about the ten women, one of whom was pregnant. One might say of this group that they were 10% pregnant.

Might I suggest that Golden and Bridger's article be made into a pamphlet and circulated widely?

MARTIN GITTELMAN, PH.D.
Faculty
New School for Social Research
New York, New York

TO THE EDITOR:

Congratulations on your October 1969 issue! One could hardly have chosen a more important theme than one concerned with

the social, educational and mental health needs of children.

However, a number of questions persist in my mind. The questions came into sharp focus particularly after reading (and rereading) the first article detailing NAMH's response to the Report of the Joint Commission on Mental Health of Children.

The article is appropriately captioned, "Action for the Mental Health of Children." The first and obvious question is—So, where do we go from here?—the "we" being all of us, individually and collectively—the reader, the NAMH, its state divisions, chapters, boards and volunteers.

Beyond the immediate circle of the voluntary citizens movement are a host of allies. The parents and PTAs, the school administrators and counselors, social workers, nurses, publicists, psychologists and psychiatrists, the Kiwanis, Jaycees, Councils of Jewish Women, the legislators, hospital or clinic administrators, the community mental health board members—and countless others.

How can their efforts be orchestrated with ours in a massive thrust to translate the Joint Commission's recommendations into the real life experience of America's neglected children?

Specific and helpful recommendations will undoubtedly be prepared and issued by the NAMH. I would highlight three suggestions applicable at the state and local levels.

1. That state mental health association divisions urge their legislatures to adopt a

Resolution (with appropriations) creating a Task Force on Implementation of the Joint Commission's Recommendations. Alternatively, to ask the State Division of Mental Hygiene, or its equivalent, to activate such a Citizens Task Force.

2. That local chapters, in conjunction with their local community mental health boards and board of education, seek parallel local action.

3. That every opportunity be taken to testify at public hearings before legislative, fiscal or other authorities to press for action in line with the Report's recommendations.

IRVING BLUMBERG
Member
Executive Board
New York State Association
for Mental Health

TO THE EDITOR:

The article by Norman Brandes (MENTAL HYGIENE 53:4) on the emotionally disturbed teacher and his influence on school children is particularly timely.

Until society recognizes the fundamental importance of education, and the enormous influence that teachers have on the young—not only during the school years, but subsequently when they become the voting populace—we will continue to have unsuitable persons in charge of classrooms. There is an old adage—You get what you pay for—and until society understands that the care of the young is the hope of the future, we will continue to have alienated youth, unsuitable persons teaching, and continued confrontations between the inadequately taught young and the establishment.

My recommendations are two: 1. Demand and uphold professional standards for teachers, paying them commensurate

with their worth to society; and 2. Require that teachers be evaluated psychologically during their training to ensure that the disturbed are not given licenses. If the first were brought into being, thereby giving recognition and status to the profession, the competition for positions might eliminate the need for the second recommendation. At the moment, because of the shortage of teachers, some persons whose inadequacies would not be tolerated in another field can get into a classroom because they are willing, not because they are able!

L. J. COWNE, Ed.D.
Brooklyn College
New York, N.Y.

TO THE EDITOR:

Your article "Has Anyone Seen My Pertinent Variable?" (MENTAL HYGIENE 53:4) was appreciated. Your later arguments concerning mothers' interactions causing or caused by schizophrenic children touches a sensitive note. Five years ago I wrote an article for the journal *Family Process* on the same topic. I felt somewhat the same way you apparently do. The hypothesis may be right but certainly the evidence has not shown this as yet. The substance of the rebuttals to my comments was that anyone who could attack the theory "just didn't know".

In MENTAL HYGIENE, as in other journals, I frequently find the most stimulating, forward-looking, up-to-the-minute and free-swinging articles in the comments, points of view and rebuttal sections of the journal.

FREDERICK T. SCHLAMP, Ph.D.
Department of Rehabilitation
State of California

Publications from the National Association for Mental Health

Policy and position statements on:

Abortion
The Disadvantaged
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Joint Commission on Mental Health of Children
Report
Manpower
Strikes by Mental Hospital Employees
Suicide Prevention
Violence and the Mentally Ill

(Free on request from NAMH, 10 Columbus Circle,
New York, N.Y. 10019)

New and revised pamphlets:

Clergy: Clergyman's Guide to Recognizing Serious Mental Illness—Single copy free. \$6.50 per C
Ministering to Families of the Mentally Ill—Single copy free. \$6.50 per C
Pastoral Help in Serious Mental Illness—Single copy free. \$6.50 per C
The Clergy and Mental Health—Single copy free. \$6.50 per C
Facts About Mental Illness—Single copy free. \$1.87 per C
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Growin' Up Ain't All That Easy—Single copy free. 55¢ per C
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Do's and Don'ts for dealing with the emotionally disturbed.
How to Deal with Your Tensions—Single copy free. \$5.00 per C
Eleven ways to deal with tensions.
Insurance in Modern Mental Health Care—Single copy free. \$3.50 per C
The current thinking concerning insurance coverage for mental illness.
Mental Illness: A Guide for the Family (revised edition)—1-24 copies 50¢ each; 25th copy and all additional copies—35¢ each
Handbook for families of the mentally ill
NAMH Publications Catalog—free.
Pierre The Pelican Series—Single set \$1.00. \$25.00 per M without imprint. \$30.00 per M with imprint
A series of 28 pamphlets on child care for first-time parents

Joint Information Service Publications

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

Approaches to the Care of Long-Term Mental Patients—\$2.50 each.

General Hospital Psychiatric Units: A National Survey—\$1.50 each.

Health Insurance for Mental Illness—\$2.50 each.

Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems—(cloth) \$6.00 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

Private Psychiatric Hospitals: A National Survey—\$1.50 each.

The Community Mental Health Center: An Analysis of Existing Models—\$3.00 each. 5 or more copies \$2.50 each.

The Community Mental Health Center: An Interim Appraisal—(cloth) \$6.50 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

The Psychiatric Emergency: A Study of Patterns of Service, 1966—\$2.50 each. 5 or more copies \$2.00 each.

The Treatment of Alcoholism—\$3.00 each.

Legal Services and Community Mental Health Centers, Henry Weihofen, \$2.00 each.

The Staff of the Mental Health Center: A field study—\$6.00 (hardcover), 4-9 copies \$5.25, 10 or more copies \$4.75.

Reprints from MENTAL HYGIENE (Write NAMH, 10 Columbus Circle, New York, N.Y. 10019)

Changing Concepts: Care and Caregivers; Matarazzo, Albee, Arnhoff, Bettis; Vol. 52, No. 2, 1968. 25¢

Cigar Box to Personality Box—art "therapy" in junior high school; DeLara; Vol. 52, No. 4, 1968. 15¢

The Citizen and Mental Health (includes list below); Vol. 50, No. 4, 1966. 35¢

The Citizen and Research; Kenefick

Citizens in Mental Health—What Are They For?; Ryan

The State Hospital in the "Bold New Approach" to Care of the Mentally Ill; Seale, Pryer, Easterling

The Clinic and the Community; Simmons

A Look into the Future of Psychiatry; Kubie

The Law and the Mentally Ill, and Aspects of Etiology (includes list below); Vol. 53, No. 1, 1969. 50¢

The Dilemma of Involuntary Commitment: Suggestions for a Measurable Alternative; Penn, Sindberg, Roberts
Some Considerations for Future Mental Health Legislation; Penn, Stover, Giebink, Sindberg
Lawyer in a Mental Hospital: The New York Experiment; Meyer
The Double Life of a Psychiatric Hospital; Davidson
Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior; Shah
The Adjustment of Criminally Insane Patients to a Civil Mental Hospital; White, Krumholz, and Fink
Legal Commitment and Hospital Behavior; Rubington

A Mental Health Curriculum for the Lower Grades: Lombardo: Vol. 52, No. 4, 1968. 15¢

Politics, Extremism, and Mental Health (includes list below); Vol. 52, No. 4, 1968. 50¢

Challenge for the Mental Health Association; Branch
Conservative Government and the Mental Health Movement: Prescription for Action. A Panel Discussion. Philips, Midlarsky, Warren
Psychiatric Politics and the Organizational Crisis; Brown
Paranoia and High Office; Kantor, Herron
Racism, the Family, and Society: A Crisis in Values; Eisenberg

The Psychiatric Patient and the State Vocational Rehabilitation Agency: A Nationwide Survey of State Agency Practices; Wolfe, Havens, Jenks; Vol. 47, No. 4, 1963. 15¢

Research in Mental Health: Results Obtained and Plans for the Future; Malamud; Vol. 43, No. 2, 1959. 15¢

From Sitter to Citizen: A Project of Vocational and Social Rehabilitation; Isaacson; Vol. 42, No. 4, 1958. 15¢

Social Action for Mental Health; Levinson; Vol. 41, No. 3, 1957. 15¢

Teaching for Personal Growth: An Introduction to New Materials; Borton; Vol. 53, No. 4, 1969. 15¢

Notice to Subscribers

With the current rise in printing and labor costs, MENTAL HYGIENE finds itself in the position of most publications, that of having to raise prices. Starting with this issue, the yearly subscription rate will be \$10. Single copies will be \$3. Subscriptions entered before January 1, 1970 will be honored at the old rates.

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The editorial staff and Board of Editorial Consultants of MENTAL HYGIENE want to take this opportunity to extend their appreciation to Mrs. Charles Franz, who recently retired as Circulation Manager of MENTAL HYGIENE. Mrs. Franz has been with the Journal since its founding in 1917. She has been a real mainstay. We regret the loss of such a dedicated and competent person, but wish her well in her retirement.



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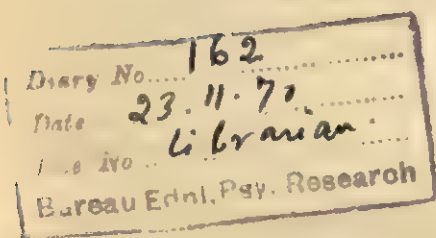
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The Psychiatrist:

Activist or Onlooker?

What is the role of the psychiatrist in today's world? Can he be content to treat individuals, or must he treat what many would have us believe is a "sick" society? MENTAL HYGIENE invited six psychiatrists of varied backgrounds to discuss the role of the psychiatrist as social activist. Chaired by Dr. Harvey J. Tompkins, the symposium examined the responsibilities of psychiatrists as professionals rather than as concerned citizens. Below are some of the comments and conclusions of the three-hour session.—The Editor.

DR. TOMPKINS: In our days, a thoughtful individual interested in his own future and that of his fellow man seeks personal commitments through active participation in a rapidly changing world, changes with which he may or may not agree in whole or in part.

It seems appropriate to determine whether the training and experience of the physician, as he specializes in psychiatry, with his study of the individual as a psychobiologic unit subject to physical-environmental influences, increase the social responsibilities of the individual who is a psychiatrist and, if so, to what degree and in what manner?

If we accept the definition that total health is dependent on physical, mental and social well being, where lies the basic role of the psychiatrist? At one end of the

spectrum some would say that he must remain primarily or exclusively patient oriented; at the opposite end, others would give him the major responsibility of being in the vanguard of needed social change.

My first question would be whether or not we can, in a practical sense, divorce the individual from his role as a concerned citizen and in his role as a psychiatrist delineate his responsibilities and contributions in participating, if he does participate, in the wide ranging social changes that are occurring at this particular time.

DR. COMER: I believe the psychiatrist has a very special role which goes beyond that of a concerned citizen. Much of what we as psychiatrists see in the way of mental health problems, are really a product of the kind of social system we live in.

SYMPOSIUM PARTICIPANTS

Harvey J. Tompkins, M.D., is Director of Psychiatry, St. Vincent's Hospital and Medical Center of New York, and former Chairman of the Professional Advisory Council of the National Association for Mental Health.

James P. Comer, M.D., is an assistant professor of psychiatry at the Yale Child Study Center and an associate dean at the Yale School of Medicine. He is the Director of Pupil Services at the Baldwin-King School Program, a cooperative effort between the Child Study Center and the New Haven School System funded by the Ford Foundation.

Alfred M. Freedman, M.D., is a professor and chairman in psychiatry of the New York Medical College and Director of the Metropolitan Community Mental Health Center at Metropolitan Hospital. He is also Director of Psychiatry at Flower and Fifth Avenue Hospital and Bird S. Coler Memorial Hospital. He is the editor, with Dr. Harold Kaplan, of **The Comprehensive Textbook of Psychiatry**.

William I. Malamud, M.D., is professor of psychiatry in the Division of Psychiatry, Boston University School of Medicine. He is Chairman of the Section of Community Mental Health of the Division and is a consultant to many community agencies, including the Roxbury Multi-Service Center and the South End Neighborhood Action Program in Boston.

Austin Moore, M.D., is an instructor in psychiatry at Columbia University College of Physicians and Surgeons and Downstate Medical Center at Brooklyn, State University of New York. He is Chief of the Liaison Service, Department of Psychiatry, Harlem Hospital, N.Y.

Robert Seidenberg, M.D., is a practicing psychiatrist and psychoanalyst in Syracuse, N.Y. He is Clinical Professor of Psychiatry at the Upstate Medical Center at Syracuse, State University of New York. He has been active in the civil rights and welfare rights movements.

"Now for us as psychiatrists to go out into the community and fight for human rights and for civil rights is a mockery, because we have not cleaned our own stables."

Therefore, the psychiatrist has a special responsibility in trying to help the people in charge of structuring the society to better meet the needs of people. It's not enough just to treat the individual and not attempt to change the society in which he lives and works.

DR. SEIDENBERG: As Eldridge Cleaver said, "If you are not part of the solution, you are part of the problem." Our credibility as people who have an interest in human rights and civil rights is worn threadbare by things we have not been outraged by in our own areas. I speak, of course, of the detention camps or mental hospitals that we have tolerated as psychiatrists for our charges. We have not been outraged enough by it, their de-humanization, their being stripped of their civil and human rights. We have stood by, we have not been active. As I said before, we have not been outraged.

Now for us as psychiatrists to go out into the community and fight for human rights and for civil rights is a mockery, because we have not cleaned our own stables.

My second point in regard to this, is the psychiatrist who—to paraphrase Winston Churchill—tries to explain so much to so many with so little. We love to make global interpretations which are really inappropriate and which have understandably turned the younger generation off, as they say. We discredit what they are doing, we either say what they are doing will make them "sick", or that they are already "sick", or that their actions are a product of "sickness".

For the present we'd best leave our psychiatric cloaks behind us when we go out into the community and try to confront people with our help, and frankly, the help that I have tried to be, is to be called on as a body. They need somebody to picket, to demonstrate, to sit in, to be arrested. They need money. I say, "Call on me and I will help you." I don't come in with any great insights or diagnoses.

DR. MALAMUD: I do not believe in leaving my psychiatric cloak behind me. I think some of the things that I was taught in terms of perceiving and trying to understand psychodynamic factors, have been very effective in making me useful to certain community organizations and their social action goals.

Secondly, I very often see a number of families that are having certain types of psychological problems, and further see how institutions, like schools, welfare departments and so forth, are playing a role in causation. By building a list or series of these, I feel the obligation to bring these findings forward and join with other groups and disciplines in trying to effect some changes.

I don't see myself as a body or a picketer, because I don't think I'd be welcome in our inner city community just as a do-gooder. I see my usefulness in the certain amount of knowledge that I could contribute.

DR. MOORE: As far as psychiatric training or knowledge is concerned, I take exception to Dr. Seidenberg's statement. My feeling is that the solutions to the social

problems that we have in this country, and perhaps elsewhere, are going to have to be found through psychiatric knowledge. We have to try to find out why these situations exist at all, how they came about. And that is going to have to fall under psychiatry.

DR. SEIDENBERG: You say it has to come through psychiatric knowledge. How have psychiatry and psychiatric knowledge dealt with their own charges of the mentally ill, as far as human and civil rights are concerned?

DR. MOORE: I don't think psychiatry has dealt with its own charges too well, either. I'm not defending psychiatry, and I'm not saying that psychiatry is not in need of change.

DR. FREEDMAN: I think one of the sources of confusion is how we view psychiatry in general, or, more particularly, the role of the psychiatrist. There really are two sets of questions that we have to put forward in our functioning in the community, and in the social sphere.

The first is the rather traditional approach of the field, which is patient-centered. One asks what there is about the history, the environment, the relationships of an individual, that make it necessary to

Then, one must ask what there is about the institutions and the structure of society that make it necessary for a significant group to behave in a certain way. In what way can the institutions be modified in order to bring help? This duality gives us the opportunity to utilize the best of our knowledge.

DR. TOMPKINS: To be simplistic, what you have said about duality is that the psychiatrist, as a psychiatrist, looks at the patient and his environment. In each instance, he has to be active both with the patient and with the environment, either by himself or in concert with others, even those outside his particular discipline.

DR. COMER: I think the fact that psychiatry hasn't resolved all mental health problems can't be held against psychiatry or psychiatrists. Psychiatrists have been outraged by conditions in mental health hospitals, state hospitals, and so on. Psychiatrists need to get more concerned about government, about the people who run our system. And, too, we have to be very careful as we move beyond the clinic that what we have to say is not misused or exploited.

DR. TOMPKINS: It is my understanding that Dr. Seidenberg feels that whatever the body of knowledge we have in psychi-

"Psychiatrists need to get more concerned about government, about the people who run our system."

act in a certain way. We treat such problems with such modalities as individual and group therapy, drug therapy, family therapy, vocational rehabilitation, as well as many others in the armamentarium of a fully functioning psychiatric clinic and hospital.

atry is, we have either misused or not used it in our dealings with individuals whom we consider to be ill. He raises some questions as to whether as psychiatrists we are prepared at this particular time to go outside of our particular "areas of competence".

DR. SEIDENBERG: I think you have summarized my position very well, Dr. Tompkins, and I would like to reply to Dr. Comer. I may have misunderstood the term social activism as used here. It really goes beyond the psychiatrist voting in elections and testifying in court. I had in mind the existential thrust of today, of people feeling there isn't too much time, that one has to exert tremendous pressure, such as going to the streets, perhaps going to jail, to make one's point.

We have elected to take care of these people. We are building our reputations on them. We are writing papers and enhancing our prestige on these people. We say we have to keep them there because we are protecting them and protecting society. We have sort of promoted the myth of the violence of the mentally ill in order to keep them there. Have we ever seen any protests or riots in mental hospitals? Are they burning down mental hospitals like they are colleges, or Watts, and so forth?

"I think that throughout most of the country there is no sense of outrage about anything."

If a surgeon were told by his hospital, or the State, that from now on he couldn't wash his hands before an operation because there wasn't enough money, he would, I'm sure, either go ahead and wash his hands, or say the hell with it.

Yet, shameful conditions exist in our hospitals—we call them hospitals, but they are detention centers. In a hospital you are never photographed or fingerprinted. When you go to a regular hospital, you don't lose your right to vote, you don't lose your right to participate in elections, you don't lose control over your property, you don't get your driver's license taken away, and you don't have to forever more put on every application to practically every industry that you have been in a mental hospital. For the mental patient, the rights of privacy and confidentiality are practically nonexistent.

Have we been outraged by this? Are we picketing, protesting, or marching for them? Are we demanding of our legislators that these people have restored to them the right to vote as well as other rights of citizenship?

DR. TOMPKINS: I am not too certain, Dr. Seidenberg, as to whether you mean that we have protested but not vigorously enough, or in the right ways, or we haven't at all.

DR. SEIDENBERG: I think we are too nice. We have been over-trained. We have gone through four years of medical school, three years of residency, perhaps five years of psychoanalysis. If we have too much invested in the system, we don't want to cause any trouble. We are frightened to death lest some colleague say, "he's acting out."

We are certainly kind and humane. We give better food, better types of shelter. As far as human rights are concerned, no progress.

DR. MOORE: I tend to agree with Dr. Seidenberg, that there is no sense of outrage. I think that throughout most of the country there is no sense of outrage about anything. Psychiatrists are people; they are part of the system, and being part of the

system for many, many years, they have more or less learned to live with it.

My feeling would be that perhaps, with some study and bringing some concrete findings to the body of psychiatry—by that I mean the psychiatric organizations, and such—perhaps more can be learned by psychiatrists, or can be admitted to by psychiatrists, that may eventually cause the rest of the people in the country to get a sense of outrage.

DR. FREEDMAN: I agree with Dr. Seidenberg that we want to make greater changes and not just work at the margins. I think there often is an implication that all the problems that psychiatrists meet with are wholly of social origin. In some cases, the major contributions are social and environmental. With others, it may be only partial.

In order to ameliorate or to help these individuals, we have to help or attack that which is appropriate. Social action per se does not necessarily cure all individuals who are disturbed. We have to develop a body of knowledge that truly can stand up. In order to approach many of the problems, we do have to increase our areas of knowledge where the gaps do exist.

I don't think a blanket condemnation of lack of progress in civil rights for mental patients is in accordance with my observations. There has been a great concern with the whole commitment procedure and the civil rights of the patient. I think the major issues facing psychiatry today are ones of delivery of services to those who need it.

DR. SEIDENBERG: If I were languishing at Matteawan State Hospital * right

now, I certainly would be very heartbroken and more about Dr. Freedman's feeling that our thrust ought to be elsewhere.

DR. FREEDMAN: The man languishing in Matteawan is very important; I'm very sensitive to those inappropriately confined there. However, direct pressure and legislation did have a significant effect on Matteawan a few years ago with the removal of several hundred patients from there. We have to set up a system of priorities in our society. As wealthy as we are, we are going to fail by at least fifteen percent to meet all our stated goals, according to the National Planning Council. So we are going to have to establish priorities, and this is both as professionals and as citizens. In terms of the social pressures and needs, I still would not make the man in Matteawan my first priority. That priority must be for improving the delivery of mental health services.

DR. MALAMUD: I think the point has been made that psychiatrists do have plural kinds of interests. It would be very unfortunate if we were to pull all of our people into one area, thereby neglecting areas that we are and should be very much involved in, where we have a commitment, and where large numbers of people would be disappointed if we were to turn our backs to them. It would be a mistake to put all our resources into our mental hospitals and deal only with the problems we found inside them, or to place all manpower into community agencies.

Another idea I'd like to introduce is our unique ability to listen and to react to needs we find from groups. This especially speaks to our ability to hear unconscious communications. Nobody has really mentioned the consumer, yet he has a policy-

* A state mental hospital for the dangerously mentally ill and those convicted of misdemeanors and petty crimes. Located in Beacon, N.Y.

determining role to play in what we do and how we conduct ourselves. Sometimes we can find the right direction by listening very carefully to what a group of people tells us.

I have had experiences where the community was saying to us, as psychiatrists, that we should use our skills in terms of intermediaries to bring both sides together rather than to picket. It might be a smarter move to meet for a non-violent confrontation and discussion rather than to mount the barricade and shoot at the other side.

I think our abilities as psychiatrists, to be able to listen carefully and understand different levels of messages and react, is a very important part of our work. Listening to the people whom we are serving, as to the ways in which they see our skills being used, doesn't mean we need to agree all the time. I think it's the ability to listen and hear what's being asked of us that's very important. Very often I think that by doing

if we are persuaded that the conceptual position is valid.

DR. COMER: By the time a situation calls for violence on the part of psychiatrists, I would think it would have degenerated so badly, along with the whole social scene, that there would be no hope anyway.

DR. TOMPKINS: Do you feel that the social situation has degenerated to that point?

DR. COMER: No, but I think we are in trouble in that we are at a critical turning point, where the demands of the year 2000 are so great, and we are still struggling with the hang-ups that were behind in the year 1900.

DR. TOMPKINS: If it's agreed that the psychiatrist could be drawn into various

"The violence comes only at the end of a sequence of steps."

this, we will keep from jumping to a premature violent confrontation. I can, however, see us at some time getting to that point, and I think the time is running short in different parts of the country.

The violence comes only at the end of a sequence of steps. For example, the agencies with whom some of us are serving as consultants, and working with, have asked us to work with them in an attempt to change the welfare laws. We have to ask at what point we bail out and say we will no longer support their efforts to get this changed, because ultimately it will lead to disobedience of the law if all other steps fail. If we really are true to our profession, I think we will go all the way with the people we are working with. This is only true

levels of violence under certain circumstances, is his possible contribution enhanced because he is a psychiatrist?

DR. MALAMUD: I think that we as psychiatrists have our greatest roles to play when we can help each side listen to the other. I can think of two or three times when an angry welfare client and an angry agency worker at the same conference have really been able, because of our ability to intermediate, to talk to each other and work usefully together and even feel comfortable in doing this. We do try to use our skills to avoid violence, and we hope that we will be successful as psychiatrists to the extent that we can avoid it. But unless we are willing to ultimately back up with force

"One of the fundamental questions that comes up is how much respect we have for our own field, that of psychiatry."

what we are saying we want, then other powerful groups are not going to listen to us.

DR. SEIDENBERG: I don't have as much confidence in our ability to negotiate as Dr. Malamud has. We are certainly pretty divisive in our own organizations. We don't do a good job amongst ourselves. If we are to be relevant at all in terms of how we represent ourselves to our patients in the community, then we have to fall on the side of humanity.

Let's face it, some things you can mitigate, some things you can negotiate, but at certain points you have to take your stand. That's why, as I said before, I give my body. It isn't as simple as that, but I feel there are other people—civil rights leaders, welfare rights leaders, etc., who know how to organize this, how to approach this. My psychiatry, my great insights, are miniscule compared to their experience and wisdom. I just ask how I can help. I don't instruct or diagnose, but instead defer to experience.

DR. COMER: I worry about romanticizing some of the movements. We can help the various groups clarify what it is they want and the way they're approaching it, and so on. We can also work with the establishment, whatever that means.

You know, there are programs being formulated in the establishment, which are supposedly designed to try and help people. This is an area where our expertise can come in. We can be very useful in helping design the new children's program,* so

* Report of the Joint Commission on the Mental Health of Children, Inc., 1969.

that it really is useful and meets the needs of the people.

There is the work with police groups that psychiatrists have done across the country. I think we have more to give than our bodies to change or to the force of change.

DR. TOMPKINS: It is not sufficient to deal only with the mental illness or the mental health complex. You have to get into the areas of housing, discrimination, hunger, obstetrical services. Here we lend our expertise to the efforts of those who might have the primary responsibility. At that level, it is more than giving bodies, because these people need to have our considered judgment as to the implication of poor housing and mental health, the implication of the lack of transitional services to the fact that a patient stays in the hospital who comes from a low economic level.

DR. FREEDMAN: One of the fundamental questions that comes up is how much respect we have for our own field, that of psychiatry. If we have respect for ourselves, then we have to think a psychiatrist can be well used. He should use his knowledge where best he can, negotiating, giving expert testimony, helping the development of various institutional changes, in halting trends that may be iniquitous.

Let's look at this notion of a sick society. This is very popular among young people now. They say society is sick, in the sense of being psychotic or disturbed. I think it is erroneous to draw this analogy. There are great problems in society, but to use this ready analogy in a sense that what we have to do is psychoanalyze the establishment or

the leaders of society, or, conversely to dismiss all these students who are causing dissonance on the campus as disturbed is simplistic.

DR. MOORE: Whatever we are going to call it, we don't want to go away feeling this is a healthy society. Whether it's individual or institutions, something is very, very wrong.

DR. COMER: I think a better word is malfunctioning society, in that the society should function in a way that it maximizes the development and the performance of every individual. And if it does not, then it creates problems which can cause mental anguish and mental illness. We have certain skills, and those skills, properly used and in the proper way, and negotiating with the correct people, or people who are best able to bring about change, can do a great deal of good.

Dr. Seidenberg has talked about skills improperly used, and that is poor psychiatry. But that doesn't and shouldn't negate or discredit what psychiatrists can do when they limit the application of their knowledge and skills to the areas where they can be effective. I think that there is a whole range of events which can be called professional actions in the social area. Then there is a range which must be called personal. As professionals, we can't become actively involved in violence. That makes us ineffective in dealing with both sides. If we have to engage in violence, it must be a personal involvement.

While psychiatrists very often have been guilty of labeling people, there are a number of psychiatrists and psychologists who

have been very much involved in establishing ideas and supporting policies which have brought about many of the positive changes that we have had in the last few years. It was psychiatrists and psychologists pushing the point of racism and what racism does that caused the Kerner Commission to come out with its very strong stand on racism. It was a psychologist pushing the problem of school segregation which helped the Supreme Court to take the kind of stand which helped bring about certain changes.

DR. FREEDMAN: Probably by present day training and experience, the psychiatrist alone will have difficulty with many of the issues we are talking about today. I would like to emphasize the need for an inter-disciplinary approach, and a collective approach, in what is a terribly complex area.

One of the greatest mistakes well-intentioned people in health, as well as in other fields, can commit is to make glib promises, particularly to deprived populations. They have heard it already. One has to approach these problems by presenting a program that actually provides services, and by developing some confidence in inter-relationships.

The grievous errors of some members of the profession shouldn't be used as characteristics. There is need for a total look at the profession, the distribution of manpower, and the enormous commitment of man hours to private practice, compared to the very difficult problem of finding adequate man hours for an institution that's not right in the middle of a city. There are the problems of getting someone to

"Whatever we are going to call it, we don't want to go away feeling this is a healthy society."

spend his time in a hospital of any sort and stick with it; of keeping residents working in community clinics and in hospital situations.

DR. MOORE: In all likelihood, today the psychiatrist will have some feelings of wanting to be a social activist. That term may be a cliché; everyone may be a different type of activist. Along the lines of activism, a psychiatrist can educate, not necessarily the people who are protesting, not the people who are deprived, but the institutions, or help the institutions to gain some insight about themselves.

Whatever we are going to call it, the "sick" society is what really needs help. We are never going to have enough residents to man the various hospitals or community mental health centers that will be needed.

"If there is a quarter of the country 'in trouble', there is still the other seventy-five percent that is running around freely doing what they have always done."

There has to be some change brought about in society itself. The psychiatrist should try to give some insight or be able to give some insight to the portion of the society that is not the underprivileged, but which makes for the underprivileged.

Everybody goes to the place where people are in trouble and wants to help them. If there is a quarter of the country "in trouble," there is still the other seventy-five percent that is running around freely, doing what they have always done. This is what really has to be coped with. This is where the psychiatrist really has to direct his efforts. The psychiatrist is going to be an activist not when he runs around and holds a placard, but when he is heard in the inner sanctums.

DR. SEIDENBERG: Aren't there people who can do a better job at this than we

can, namely political leaders and those people who know the techniques of swaying people? How are we going to educate a hundred and seventy-five million people?

DR. MOORE: We have to educate the political leaders. Political leaders are practical people. It's obvious there has to be a pragmatic view. Perhaps a psychiatrist might serve the purpose. A social activist psychiatrist could show political leaders where, in ten years, if they do such and such and such, this will be very much to their benefit.

DR. SEIDENBERG: Where has the psychiatrist learned the political and social know-how to know what's going to happen ten years from now?

DR. MOORE: He knows people well enough to know what's going to happen. He can use his knowledge to say, I would think, that one of the best things we can do is A, B, and C. You may think that it's D, E, and F, but my evidence and my data show that A, B, and C are really what's going to happen. We have to consider the fact that the opinion of the psychiatrist is respected, outside of medicine.

DR. SEIDENBERG: I just don't see this body of knowledge. How do you know that the advice you give is really not just your philosophy?

DR. MOORE: If four of us get together, we are going to show some objectivity in the conclusions that we arrive at. I don't

mean one person should dictate things. But if four of us decided we were going to sit down, and over a period of time we come to some conclusion, some of my philosophy would come through, but it might be negated, because you would say that it doesn't sound like it's so, but that it sounds like it's what I wish. I think the role of the psychiatrist as a social activist does not have to be simplistic. Whether one tries to help by doing sixty hours of psychotherapy a week in underprivileged areas, or by carrying a placard, there are other things that the psychiatrist is peculiarly suited for which involve his training.

DR. COMER: I wouldn't want to leave this conversation without challenging the notion that there isn't a body of knowledge. There is a huge and documental body of knowledge about human behavior, tested, you know, particularly in the child development area, and this country is farther behind any other industrialized country in what we are doing to help children to develop adequately. That alone speaks to chaos in a few more years, unless we do something about it.

DR. SEIDENBERG: What are we going to do about it? That's crucial, too.

DR. FREEDMAN: I can illustrate from my own experience in an area I have been involved with a good deal—the whole question of legislation concerning drug abuse. I have testified before the Senate and other bodies. There are certain obvious points one can make, such as the effects of labeling an adolescent as a criminal. We know that puffing one marijuana cigarette does not lead inevitably to criminal insanity. You can take a stand on this, and be effective in

influencing legislatures and trying to influence other bodies.

I think that one has to combine with other citizens in order to affect programs. There are a number of individuals, legislators, and others who are eager to get some expert knowledge of what is known right now and what can be done about it.

DR. TOMPKINS: I am reminded that within the last year the Committee on Foreign Relations of the Senate has initiated sessions with various social scientists, psychiatrists, psychologists. I would hope that this visibility at the federal level would enhance our opportunity of doing likewise at other levels of government.

Reference has been made to our working together on these issues. For most of us, one common bond is membership in the American Psychiatric Association. It represents about seventy-five or eighty percent of the psychiatrists in this country. Is it the proper vehicle for the form of activism we have been discussing?

DR. SEIDENBERG: A recent issue of the *American Journal of Psychiatry* points out that some seven thousand psychiatrists, mostly young ones, have not joined the APA. The author of the article suggests that the APA spend more time on image-building to attract these young people. He is upset because public opinion surveys show that psychiatrists are not identified with medicine in the mind of the public and feels that more should be done to strengthen that identification.

I would like to throw out some questions such as should we spend our time on image-building and is our relationship to medicine a hindrance or a help in our work? As physicians, perhaps we tend to "treat" things rather than "deal" with them.

DR. FREEDMAN: I'd like to pick up on the first issue, that of the APA, the establishment. A well formulated long range psychiatric policy for the United States has as yet not emerged from the APA. There are a lot of pragmatic statements or organizational statements that handle immediate crises, but when you look for a formulation of a long range plan in regard to research or delivery of services, it's not there. We are responding to where the pressure is, oiling the squeaky wheels. We ought to try to get far ahead of the problem. We have to be concerned with, rather than image building, model building. For instance, what will be the model of psychiatric practice in the 70s? Possibly our current private practice model will disappear when new national programs are set up.

As regards our relationship with medicine, I think psychiatry has an exquisite role at the interface between social policy, social sciences, political problems and health problems. We have a foot in both fields. The trend for the 70s will be towards human services in general. Psychiatry can play a leadership role in this, and strategically this is where we should push ahead. This is health and mental health. We should not relinquish whatever ties we have with medicine in general, while at the same time reaching out in the broad area of social practice, education, welfare and others.

we have to consider, the National Institute of Mental Health. It's their policies and the procedures that have developed which, in the last twenty years, have guided many of us in terms of what we have attempted to do in psychiatry. NIMH's influence has been strong in the educational and research fields, and increasingly in the development of methods of a delivery of services.

Where do you think the APA will go to get a grant for five years for this particular study? NIMH?

DR. COMER: This ties very neatly back to our first concern about political activism and what the psychiatrist can do. The psychiatrist concerned about social problems has to be concerned about NIMH and the APA, and the kinds of political pressures they're under. NIMH is in a very tricky position. There are political pressures on one side, and the need for respectable support from educators, or university people on the other. As a result, certain kinds of research get favored because the academicians are involved. This, then, affects the delivery of service.

DR. FREEDMAN: There has to be a statement that should come from outside the government, from the professionals and consumers, of what the needs and the desires are for, in regard to delivery of ser-

"We are responding to where the pressure is, oiling the squeaky wheels."

DR. TOMPKINS: I might say that recently the APA has developed a commission on delivery of mental health services—a five year program to look at the long term view.

However, there is another organization

vices, in regard to training, in regard to manpower and in regard to research.

NIMH, although it is the dispenser of all the goodies, has certain constraints upon it. It is part of the political establishment and it can, certainly, be limited and have

various pressures exerted upon it. Here I think an outside group, or groups, that work together, could be immensely important.

DR. MOORE: Speaking as a psychiatrist as a social activist, perhaps we can take off at this point and discuss the influence of the NIMH upon the APA. This has nothing to do with ghetto residents and underprivileged people, except in the final analysis. Perhaps this is where a psychiatrist, as an

to which you can refer. Otherwise, you are very dependent upon capricious events, and one has to respond immediately to a given situation instead of trying to exert pressure for funding along certain agreed-upon lines of both professional and consumer, and put up a genuine struggle for that. Otherwise, you go from year to year and from budget to budget.

DR. TOMPKINS: In order to do this, you have to forge a basic philosophy and,

"It is still possible to get through a psychiatric training program with almost no background in social sciences."

individual, and as a respected member of society, can be a social activist. This is, in the end, what really needs changing; sending ten million dollars up to 125th Street won't help.

DR. TOMPKINS: Often NIMH is the only place where funds are obtainable and this makes it pervasive in terms of its influence on practically every recognized mental health unit in the country.

DR. MOORE: To use Dr. Seidenberg's word, where is the outrage? If you don't have outcry from APA, from a secure group of forty thousand dollar a year men, where are you going to get it—from somebody who makes fifty dollars a week?

DR. COMER: Again, the fact that even the establishment gets its funds from NIMH does not discredit everything that the establishment has to say.

DR. FREEDMAN: This is the reason I tried to emphasize the great necessity for mental health policies, long range policies

in terms of the implementation, you would be forced into a system of priorities. Are we ready for this at the present time?

DR. FREEDMAN: I think we ought to start working on it. Probably it would be difficult at first. I think there is need for it and it has already been begun, as you pointed out.

DR. TOMPKINS: I was stimulated to ask that question by the fact that the APA commission on delivery of mental health services that I talked about seems to feel that we have to immediately think in terms of total health services. As we think of a national policy in mental health, we have to relate it to the total health field.

DR. COMER: This total approach highlights a deficiency in psychiatric training. It is still possible to get through a psychiatric training program with almost no background in social sciences. One of the reasons I think that we focus on the individual without looking at the interaction between the individual and the society is just because of our kind of narrow training.

DR. SEIDENBERG: How can we do that if we insist that the psychiatrist know how the circulatory system works, and the endocrine system works? You can't do everything. You have to have some priority.

I would like to ask Dr. Freedman if he finds that his medical education is relevant to the things he is doing now—such as the testimony he gives to the Senate and the catchment area he has, and the many things he does to promote mental health.

DR. FREEDMAN: A good deal of the medical education was relevant. I also wish I had had time to take a Ph.D. in political science or in sociology. I think medical education has to be altered in light of the new responsibilities. This applies, even more clearly, to medicine in general, where the management of chronic diseases, or the reduction of whole prenatal complications, are, to a significant degree, social problems. I think that we have to change the curriculum of medical schools, such as having a very condensed core education with many opportunities for electives, so that the man who goes into psychiatry will spend most of his time in the relevant areas.

DR. SEIDENBERG: You wouldn't give up your medical degree, in other words?

DR. FREEDMAN: I would not.

DR. TOMPKINS: Today we've looked at the relationship of the psychiatrist to the establishments within his own society. There is a role for the psychiatrist today towards powerful, relatively blind institutions that go on functioning and may not always function in a way that's consonant with reality.

Another interesting topic is medical education, psychiatric education. We present ourselves to the public as purveyors of vast amounts of knowledge, though there is room for skepticism about this.

If we are really to fulfill the role that we are implying as proper for psychiatrists, what should be crammed into the psychiatrist's head? What kind of practice should he contemplate? What and how should you teach him?

We could spend several more hours on these topics. I think it's clear, though, that there is a definite role for the psychiatrist to play as a social activist as well as a healer. Whether the former means picketing, testifying in Senate hearings, or mediating between community groups, we can no longer be content to reserve ourselves only for treatment of individuals. We're still groping to find the best way of "treating" individuals and society; this remains a challenge none of us can ignore.

Sheldon K. Schiff, M.D.

Community Accountability and Mental Health Services

The author compares two community mental health centers in urban settings and points out the problems to be faced by white professionals in their relationships with the Black community.

The turmoil at Lincoln Hospital,^{5, 7, 8, 24, 25, 27, 28, 32, 37} the activities of Black mental health professionals at recent professional meetings,^{22, 23, 31, 33, 34, 35} and the New York teachers' strike of 1968¹⁸ would seem to indicate that there is a special problem in the relationship of the white professional working in a Black urban community. It would be more accurate, however, to see these occurrences as merely highlighting the problems and ambiguities that surround the emerging collaborative relationship between mental health professionals and the communities they serve.

The mental health professional's responsibility to the community—as opposed to his responsibility to the individual patient—has traditionally received little recognition in professional training and practice

until recently. The events of the past few years, and particularly those of recent months, have served to greatly emphasize and confound the racial aspects of a long-standing problem—what the relationship should be between professionals and the community.

The great majority of reports describing implementation of large-scale mental health programs of study or intervention prior to the events at Lincoln Hospital revealed that similar difficulties have been encountered by white professionals in white, non-urban communities.^{1, 4, 13, 15, 26} Because of today's pervasive intensities, the historical roots of these difficulties have been obfuscated and our perspective of the problem and its solution has been distorted. However, the role of the community in effecting professional change in mental health has historically been related to societal change and conflict.^{2, 23, 42}

Dr. Schiff is the Co-Director of the Woodlawn Mental Health Center, 841 East 63rd St., Chicago, Ill. 60637 and Associate Professor of Psychiatry, Pritzker School of Medicine, U. of Chicago.

If one looks at two of the earliest community-professional relationships developed following passage of the community mental health centers' legislation, that of the Woodlawn Mental Health Center in Chicago and Lincoln Hospital in the Bronx (New York City), there are certain differences and similarities that have been sources of major problems contributing to the tensions reported in both experiences.

Both, for example, are municipal facilities affiliated with private universities; both are substantially funded by additional governmental and private sources; both are located in urban ghetto communities; and both are directed by white professionals. At Lincoln Hospital, tensions partly attributable to these characteristics led to the disruption of program activities; the Woodlawn Mental Health Center, on the other hand, has operated continually over a period of six-and-a-half years.

The mental health professional engaged in the development of innovative programs often finds it difficult to resist the inducements of academic title and security, rapid professional recognition, political power and station, or a role in local community policy-making.

There are three distinctions basic to any discussion of the ongoing, though not untroubled, operation of the Woodlawn Mental Health Center and the recent discontinuance of Lincoln Hospital's mental health program: 1. The nature of the mutual responsibility defined in the professional-community contract and its mechanism of implementation; 2. The nature of the professional's primary professional and institutional bases and their effect upon the

content of this contract and its implementation; 3. The effects of the contract upon the role of the professional and the nonprofessional.

The Professional-Community Contract: The Woodlawn Mental Health Center Board

The early difficulties of the Woodlawn Mental Health Center were related largely to the professionals' inadequate training in community involvement, their inexperience, and their lack of understanding of the professional-community relationship.^{9, 11} The community itself suggested what was probably the most important mechanism developed to meet this problem—a community advisory board.

The Center's advisory board included approximately twenty-five community citizens who related to the professional directors of the Center with only informal powers of consent. However, from the beginning it was mutually understood that this board would not only provide community sanction for the Center's programs but play a central role in planning the use of non-professional community resources. The commitment of the Center's professional staff was to discuss with this board all major decision-making necessary to the Center's operations.

During the few years of the board's advisory status, one of the co-directors assumed the chairmanship of board meetings. As the board became more intensely involved in the Center's developing programs, and as the Center gained increasing acceptance in the community, the chairmanship became a source of some controversy. Board members came to feel that having a mental health professional as chairman vitiated their own roles—particularly with respect to their responsibility to the community groups many board members represented.

As time went on it became clear to everyone that the board had moved to a more autonomous position. The chairmanship was subsequently assumed by a board member and shortly thereafter the group framed a constitution which described the formal structure of a full-fledged community board with powers to advise and consent. This included all aspects of the professional staff's involvement with their university departments, the city board of health, and other community agencies.⁴³

The Contract at Lincoln Hospital and its Effect on Community Support

The Lincoln Hospital operation included no mechanism for community involvement. Although Lincoln Hospital is a municipal facility, through a contract with the City of New York, Albert Einstein College of Medicine was designated as the responsible fiscal and operating authority. Subsequent funding from federal agencies, largely the National Institute of Mental Health and the Office of Economic Opportunity, was also administered through the university business office. At no time was there any effort to involve a constituency of concerned citizens in the planning and implementation of the hospital's programs. Community boundaries, program goals, and even more important—program priorities—were all determined by the professional staff. As a result the nonprofessional became the only conduit to the community—initially as part of a rationale, and later by default and the momentum of events.

Despite a substantial financial base amounting to a budget of \$4 million a year and widespread professional endorsement, the Lincoln Hospital operation was critically vulnerable with regard to its professional-community contract. It was the ambiguity and indirectness of this contract that was to surface ultimately as the critical

flaw. As one of the directors candidly stated, the single most potent factor pertinent to "the escalation of the conflict" was the professionals' initiation of the program "without organized and coherent community support and sponsorship."³⁷

The Professional's Primary Base and His Community Contract

The professional's vulnerability to being politicized is perhaps greater than that of the nonprofessional. The mental health professional engaged in the development of innovative programs often finds it difficult to resist the inducements of academic title and security, rapid professional recognition, political power and station, or a role in local community policy-making.

Both the Woodlawn Mental Health Center and Lincoln Hospital have similar sources of funds. In contrast to Lincoln Hospital, the Woodlawn Mental Health Center's budget from city and state grant-in-aid funds has been small. For the first four years it remained unchanged—\$125,000 a year. As a result of the board's intervention, this amount has been increased slightly, but remains less than \$200,000 a year in useable funds.

The directors of the Center made the deliberate decision to be funded by the local public health structure rather than be dependent from the outset on grant funds. Also, since the determination of program priorities was a function of the board, the directors made no effort to secure grant funds until the first program focus was specified. Only after the board had made its decision to develop a program for young children primarily concerned with prevention did the directors seek supplemental grant funds.

Thus, the first two grant awards supported the development of a mental health

program for all the first-grade children entering the twelve Woodlawn elementary schools each year.^{10, 12, 40} These grants supported the program of prevention and early treatment,* its evaluation of effectiveness, and associated studies.** In the meetings devoted to these grant applications, the board insisted upon the right to review all future reports of this work prior to publication and upon their primary rights of ownership—with due respect to medical confidentiality—of all the original information and data collected in connection with these efforts. It was the board's contention that their activities in obtaining community support and cooperation were based upon their own accountability to the Woodlawn residents for what resulted. The directors of the Center agreed to both of these conditions.

Grant funds awarded to the Center were administered from the very beginning by the university,*** just as they were for the Lincoln Hospital staff. During the early years, perhaps because the amounts and staff were small, there was little of the kind of fiscal administrative problems described at Lincoln Hospital.³⁷ However, in recent years similar problems have been encountered more frequently.

* A grant from the State of Illinois Department of Mental Health, Research and Training Authority, DMH No. 17-322, awarded for a three-year period beginning July 1, 1965. (Principal Investigator: S. G. Kellam, M.D.; and Co-Principal Investigator: S. K. Schiff, M.D.)

** A grant from the National Institute of Mental Health 5-ROI-MH-14807, awarded for a five-year period beginning January 1, 1966. (Program Director: S. K. Schiff, M.D. and Co-Director: S. G. Kellam, M.D.)

*** For the first three years of its operation, the Woodlawn Mental Health Center was affiliated with the University of Illinois Medical School Department of Psychiatry. Since that time it has been affiliated with the University of Chicago Pritzker School of Medicine, Department of Psychiatry.

In such innovative contexts, the academic goals of study and instruction can be confounded by those of social welfare and the need for social action.

These developments have paralleled the increased grant support and program expenditures, and the growth of the Center's staff. They have been associated also with the expansion of part-time staff from the community, comprised mainly of parents and teachers,⁴¹ and the geographic separation of the Woodlawn Mental Health Center from its university medical school department—a problem the Center shares with Lincoln Hospital.

The problems experienced by a department of psychiatry and its faculty as a result of its association with innovative programs are mutually discomforting. In an article published in 1964, the Chairman of the Department of Psychiatry at Albert Einstein Medical School commented on the not entirely pleasant impact of such programs upon training and upon his own values with regard to psychiatric practice.³⁹ In such innovative contexts, the academic goals of study and instruction can be confounded by those of social welfare and the need for social action.²⁰ The enthusiasms of the teaching staff may then become merely ideologic and exhortative in nature. Also, departmental chairmen engaged in the arduous tasks of maintaining and building a department may see such developments as competitive. A number of psychiatric department chairmen have expressed these and still other concerns about these kinds of program associations.^{6, 10}

While not unhappy about the funds or the publicity which attends these efforts, most medical schools and their universities are rightly concerned about the possible disadvantages and dangers of such experi-

mental innovations. Certainly they raise the spectre of an expensive service commitment which is neither in keeping with department staff capacity nor ideal for an adequate academic standard of teaching commitment.

It is, however, the concept of community participation and community prerogatives that is most threatening to both department and university alike. For many universities located in urban ghettos, the possibility of ghetto area residents organizing and demanding a redefinition of their mutual relationship with the university is viewed with considerable caution and uneasiness.

A well-designed, specific professional-community contract is certainly a key factor in transforming this threat into a positive force for effective programming. The construction of such a contract, however, must also take into account the many practical realities of administering the service programs. For the community this is an issue that is integrally related to their concern with the prerogatives defined by such contracts. Ultimately, service is one of the crucial factors in their wanting the right of accountability.

The Effect of the Contract Upon the Nonprofessional

In the event a professional-community contract is faulty and fails, the most adverse consequences with regard to staff fall upon the nonprofessional. Members of this group, consisting of previously untrained residents of poor communities, are acutely aware of the newness of their occupation, uneasy about the responsibilities they have assumed and their ability to carry them out, and concerned about how they are viewed by the professionals and patients with whom they work. As a result, their potential to be "politicized" is directly related to

the ground rules set by their professional supervisors.

The source of many of the actions and statements of the nonprofessional staff during the difficulties at Lincoln Hospital can be traced to the training and supervision by the staff professionals. First, the nonprofessionals were hired both as staff and as community citizens with little if any distinction made between the two roles. Indeed, the use of Community Mental Health Workers as a source of community information, program feedback, and a kind of public relations liason was part of the early concept of the nonprofessional role. Certainly, in the absence of any independent citizen board, the nonprofessionals were preeminently more qualified to "speak for the community" than were the professionals; but the duality of their function was a serious fault.

Second, the first director of Lincoln Hospital's storefront program directed too much of his training toward efforts to make the student comfortable and confident in his new role.³⁷ The nonprofessional student's abilities were oversold by comparing his unique attributes—a result of his cultural background and community residence (both important employment criteria)—to the patent lack of the white middle class professionals in this area. Hence, the confidence and comfort of the nonprofessionals at Lincoln Hospital was secured at the expense of the professional's role and areas of competence. The result was the negation of what should have been a respect for the mutual expertise and background of both professional and nonprofessional.

Third, the "new careers program" for nonprofessionals offered a solution to the problem of their occupational future.^{38, 39} It was interpreted as providing entry points into the professional's hierarchial ladder, thereby securing for the nonprofessional

status and financial reward on a par with the professional. In light of the first and second points, it is easy to see how this experimental innovation was conceived. It was an unfortunate experiment for many reasons. The legitimate question—never fully entertained at Lincoln Hospital at any point—as to the true effectiveness of the nonprofessional's role and function was sidetracked. While this question is, in the main, unanswered for the professional, it is vital to the nonprofessional's self-respect.

Although it is clearly recognized today that the mental health professional's credentials are no guarantee of "cure" for all problems, this is not to say such credentials are without significance. The nonprofessional does not have professional credentials and should not be endowed with identical license. It is plain that the Lincoln Hospital program dismissed the professional's expertise too lightly,⁸⁷ viewing his societal rewards as simply and totally issues of social powers not related to a highly marketable competence. This view had the grave disadvantage of polarizing the broader professional community against the nonprofessional and casting him in a pejorative self-seeking role which is largely unwarranted.

The Woodlawn Mental Health Center, because of its current organization of programs, is not entirely free from this serious and potentially fatal development—a politicized nonprofessional staff. There have been efforts by individual staff members, community groups, and others to influence the hiring and dismissal of staff members. However, the formal procedure of introducing each prospective nonprofessional staff applicant to the board for final approval after they have been interviewed and screened by the responsible professionals has been a great help. The board's Executive, Personnel, and Grievance Committees, con-

stituted to resolve such problems, have been extremely successful. The Committees are available to any staff member who wishes to present a grievance or have a dismissal reviewed.

With the help of the board and its growing awareness of its singular responsibility in this area, further plans are underway to eliminate the weaknesses that still exist.

Discussion

The term "community control" has been eschewed deliberately in this paper in favor of **community accountability**. The most compelling reason for this distinction is that community control, as defined by the usage of both its advocates and its opponents, has broad negative connotations. Community accountability, on the other hand, is not only a less emotionally-charged term, but is, in fact, a more precise description of the real issue to be discussed.

The recent experiences at the Woodlawn Mental Health Center and at Lincoln Hospital have shown clearly that those most vehement in their demands for community control have been members of the professional and nonprofessional staffs employed by community agencies, schools, and in only a few instances, community organizations. With rare exceptions, they have not been the parents and other resident citizens of the respective communities. The parents of the more than 10,000 first graders who have been involved in the Center's school mental health program have been and continue to be primarily interested in the current and long-range effects of the program and the school system on their children.

One of the major responsibilities of the Center's board is to insure that the staff of the Center and the schools are accountable to every parent and neighborhood resident. The board is committed to providing every Woodlawn resident the right to be

With few exceptions, the various staff members advocating community control did not live in Woodlawn.

"heard out", regardless of the nature of the concern and without any *a priori* judgment of its legitimacy.

The board has been crucial also in resolving the tensions generated by the demands for community control by the professionals and nonprofessionals. It was through the active participation of board members at public and private meetings with school faculties, staffs of other agencies, and community organizations that the fundamental question of who constituted and should represent the "Woodlawn community" was resolved. Members of the board recounted the history of their relationship to the co-directors, their investigation of the directors' views as white psychiatrists, how the directors' professional relationship with the community was defined and the nature of that relationship. In many instances, these were the same questions being advanced to Center staff by groups concerned with the "interests" of this Black community. The board forged a bridge of working understanding and successfully clarified the definition of the community and its citizens, making the distinction very clear. The buttressing of this bridge is a continuing process.

With few exceptions, the various staff members advocating community control did not live in Woodlawn. They resided in nearby, more middle class neighborhoods and, by their education and income, clearly belonged to a different socio-economic class than the Woodlawn resident. It became very apparent that in feeling qualified to "speak for the community", they also expected to become the direct possessors of "community control". These were important issues to define and resolve—and neither could have been accomplished by

the Center staff alone or by any programmatic design.

It is not the intention of this paper to present the Center's professional-community contract or the Woodlawn Mental Health Center Community Board, the mechanism by which it is implemented, as being without serious flaw. The experiences of the Center and its board—particularly those of this past year—have made it clear that this design does not eliminate the possibility of policy actions which are in direct conflict with the primary mental health aims to which the professional staff and members of the community board are mutually committed. A variety of parochial self-interests of individuals, community groups, professionals, or affiliated institutions can threaten the fulfillment of this contract. Only by maintaining the unencumbered commitment of each board member, together with the board's ongoing participation, can capitulation to one or another of these self-interests—by either staff or board—be prevented.

It has been the intention of this paper, however, to point out that community control is not only far from being a solution in itself—a position that is not uncommon these days—but it represents a concept which seriously threatens the ability of poor minority communities to realize those rights of accountability guaranteed by our constitution, and already available to the citizens of white middle class communities. If this kind of control is obtained, it will undoubtedly be the result of the decision by the pertinent vested interests that they no longer want it—not because control has been wrested away by successful strategy. Control over a bankrupt enterprise pockmarked with a multiplicity of complex

problems and fiscal needs would be a Pyrrhic victory indeed.

There have been a number of reports describing the failure of community action programs.^{8, 17, 19, 20, 21} Some have revealed a disturbing pessimism about the ability of poor communities to effectively alter their own condition.^{17, 20} Few of these reports address themselves to sources of failure other than the community citizen. Culpa-bility for these failures must also be assessed in the light of the problems presented by local government, agency professionals, and, in the private sector, the role of the university and large foundations.^{8, 18, 19}

Unless serious attention is focused upon these other sources of failure, the consequences for both the recipients of mental health services and those who provide such services (nonprofessionals as well as professionals) will be disastrous.

There is great likelihood that the role and function of the mental health professional will be fixed into rigid, traditional modes that allow little more than token experimentation and innovation. Similarly, graduate and professional schools responsible for training mental health professionals will be less likely to support investigations, programs, and teaching efforts which have major public health commitments rooted in the community rather than in the hospital-clinic context.

The nonprofessional's future will be even more imperiled. For these new career lines to develop in directions complementary to the professional's inexorably specialized role, there must be the kind of professional freedom which is now only minimally available, but which will be almost totally curtailed by the fearful, defensive reactions to community control.

With the exception of the Communist countries,¹⁴ the difficulties experienced in developing effective professional-communi-

ty contracts in poor communities are magnified in poor nations around the world. The advantages of the democratic principles embodied in our constitution, the number of professionals available and the capacity to train such professionals, and a gross national product sufficient to develop human services—particularly those largely professionally-oriented—are almost non-existent in most of these nations.

Control over a bankrupt enterprise pockmarked with a multiplicity of complex problems and fiscal needs would be a Pyrrhic victory indeed.

It is for these reasons that the innovations now being tested such as community mental health centers, community school districts, and others which utilize large numbers of nontraditional professionals, represent an immense promise. The premature and unwarranted rejection of these innovations, then, has even larger implications.

The academic professional and the university, because of their traditional role and mission to pursue new knowledge through free inquiry and the preservation and transmission of knowledge already gained, have a unique responsibility. They represent a singular capacity for independent and objective examination of community service programs and their sources of failure. Regardless of their increasing burden of conflicting self-interests, critical investigation of these failures by the academic professional and the university is greatly needed. Without their contribution, it is doubtful that an effective solution to this problem will be obtained.

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Libbie B. Bower, Ph.D.

Barbara Elam, B.S.

Developing an inner city mental health association

The authors were intimately associated with a unique community organization phenomenon which resulted in the formation of a Mental Health Association in a predominantly Black, economically deprived section of Metropolitan Boston. The Fort Hill Chapter described below, with its imaginative programs, should serve as an exciting and challenging example of what can be done by a group of citizens sufficiently aroused about the lack of mental health services in their own community.—The Editor

The organization of the Fort Hill Chapter of the Massachusetts Association for Mental Health had its historical roots in the work of the Mental Health Committee of the Boston branch of the Delta Sigma Theta Sorority, a national service sorority. In 1959, and 1960, Mrs. Harry Elam,* chairman of the Mental Health Committee of the sorority, in cooperation with staff of the State Department of Mental Health and the Massachusetts Association for Mental Health and a wide range of local social, civic, fraternal and religious groups in the Roxbury community, conducted one-day educational programs on "Problems of Community Mental Health".

Evaluation of the day's work reflected high interest on the part of the community,

Dr. Bower was formerly a consultant with the Massachusetts Association for Mental Health, 38 Chauncy St., Boston, Mass. 02111. Mrs. Elam is a former librarian and is very active in civic affairs.

and there were requests for additional programming.

Two later developments were to play a major role in the formation of the chapter. One was the recommendation of the Massachusetts Mental Health Planning Project for the reorganization of the State Department of Mental Health into 37 areas and 7 regions throughout the Commonwealth with local citizens on area advisory boards. The recommendation was subsequently enacted into law.

The other was the long range plan hammered out by an Ad Hoc Committee of MAMH during the same period which provided for chapter development to coincide with the geographical areas and population base of the Comprehensive Centers, particularly in the core city of Boston, Region 6.

* Member Advisory Council, Boston Mental Health Survey 1960-62.

The Massachusetts Mental Health Planning Project * rated the area in Region 6 which includes Roxbury, Back Bay, North Dorchester and the South End as being of highest priority in terms of mental health needs. This region had the largest percentage of families with incomes of less than \$3000 per year in the Commonwealth. It ranked first in the number of welfare recipients on old age assistance, medical aid to the aged, disability assistance, aid to dependent children and general relief.

More people in the Boston University area are admitted to all mental hospitals than from any other area and fewer are released after one year than from any other area.

The 1960 census data showed 150,114 people living in the area, 36.1% of whom are Black. The area is serviced by the Boston University Comprehensive Mental Health Center.

Because of the promise of citizen participation on the area board and the need to implement the Ad Hoc Committee's recommendation, especially in the area where need was greatest, staff was assigned to organize a mental health chapter.

Mrs. Elam was apprised of the plan. It was her suggestion that the Delta Sigma Theta Sorority could help.

The Deltas responded by participating in some programs for self-education. They not only proposed a plan for chapter development, but recruited a co-chairman, Mrs. Thomas Wright, to work closely with Mrs. Elam.

Mrs. Wright assumed major responsibility for providing a series of educational programs for community groups; Mrs. Elam assumed major responsibility for setting up

conferences and visits with over 40 key leaders in the community to interpret the purpose of a citizens mental health organization.

The educational chairman responded to requests from tenants associations for a series of meetings on mental health, church group requests for parent-child education programs, requests from branch libraries for discussion on mental health topics, requests from community action programs to keep them abreast of mental health legislation, requests by community aides for mental health orientation, requests for consultation for volunteers of the homebound elderly. Talks were scheduled for inter-agency council luncheons which provided a platform for discussion of the role and function of a citizens organization. All the educational programs utilized professional and non-professional resources in the community. Literature was provided upon request and, as has been our practice in broad public education programs, requests for referrals for help were followed through to the most appropriate agencies.

This kind of educational exposure provided visibility for our community organization efforts; it also assisted in developing trust and confidence on the part of the community as members became involved in the planning and carrying through of the programs.

From the beginning, as we worked with community groups in the educational programs, we demonstrated our conviction that creativity can come up from the grass roots by using the non-degree person, with little formal educational background, not only in the planning, but in the decision-making processes. For example, at one program a citizen from a large housing project related her volunteer activities in helping a neighbor go through the admissions unit of a state mental hospital. She talked knowl-

* Mental Health for Massachusetts: The Report of the Mass. Mental Health Planning Project, State Department of Mental Health, 195 Portland St., Boston, Mass., 1965.

At times we felt that single meetings just barely scratched the surface of issues and problems raised—that people were reaching for something more.

edgeably about the delays while waiting for staff; about the impersonality of the procedures. Another citizen shared some of her experiences as she sought help for her adolescent boy . . . "lack of psychiatric resources", confusion and disillusionment as she was "shunted from agency to agency." They did not leave their comments on the level of criticism—rather they made suggestions as to how to change the traditional delivery of services to make it more relevant to today's needs.

Not all the public education programs were rated high in acceptance. We used a brief reaction sheet at the end of many meetings and learned much from it. For example the film *Shyness*, used with a parent group, was rated as "pie in the sky" for "our schools here in our community". "It was unrealistic," people said, "to expect teachers in our schools to work with children in such a sensitive, understanding way when such a large percentage of teachers are substitutes—never get to know the children. This film is about white children and their middle class styles of living; not relevant to schools in the black ghetto."

At times, we felt that single meetings just barely scratched the surface of issues and problems raised—that people were reaching for something more. Our experience, however, with such educational programs, did give us clues about structuring them in more meaningful and productive ways.^{1, 2} It also started efforts in search of educational films dramatizing the human condition of the Black family.

Concurrent with assisting in developing educational programs, the staff of MAMH conferred with approximately 40 commu-

nity representatives from all walks of life. The contacts cut across the economic ladder from the unemployed, the underemployed, the laborer, to the middle class and the affluent.

The two primary purposes of such conferences were to interpret the role and function of a citizens organization and to draw out the feelings and ideas of the people interviewed. Such visits encouraged questions and comments in relation to their own experience with the field of mental health and enabled people to voice their concerns and their hopes for comprehensive services with the implementation of the new legislation.

Some of their common concerns centered on: the need for services for the emotionally disturbed child; the need for mental health education for parents, for teachers; the problems of the school "drop-out"; and rehabilitative services for the returned patient. Throughout the conferences, there were feelings expressed directly or indirectly of deep frustration in regard to: discrimination in housing and employment practices, inferior schooling and exploitation of the ghetto dweller.*

In addition to the public education programs and individual conferences described previously, three other programs were initiated during the formative period of the Fort Hill Chapter: ** the High School Careers Program; the training of youth recruited from Neighborhood Youth Corps Centers as hospital attendants or case aides;

* In the past year, the chapter appointed a committee on Social Issues and Social Policy.

** The name of the chapter was derived from a landmark of the Revolutionary War.

and in-service training for teachers in a large school district in Boston.

Since 1963, students from high schools in Metropolitan Boston have been assigned to the Massachusetts Mental Health Center and Boston State Hospital as part of a career program sponsored by MAMH and the state schools and hospitals. With the development of the Fort Hill Chapter in 1967, intensive work was initiated by the chapter representatives to recruit Black youth to participate at both hospitals. It was felt that a Black chapter representative would provide a more meaningful model and could project an image of a person with whom students could identify. This assumption was tested out during 1969-70, and there was an increase in the number of Black students participating. However, there were other factors accounting for lack of larger numbers coming into the program. In addition to working after school, transportation costs to the hospitals accounted for some of the difficulty in recruiting young people from poverty areas and is a problem that the chapter hopes to solve.

Although the goal of the program was directed toward mental health career stimulation, the chapter has found the community responsive to such an innovative program from an educational viewpoint as well. For example, at the end of the school year, when certificates are awarded to the students in recognition of their extracurricular work, parents, friends, neighbors, and school faculty attend. Newspaper publicity brings the program to the attention of the public.

Although it is too early to identify those who have chosen one of the mental health vocations because of their participation in this program, it is of considerable interest to the chapter that several of the students who have participated in past years, are majoring in one of the mental health or allied

disciplines. Also, as contact is made with individual students as they continue on in college, it is observed that some have functioned in leadership roles in assisting with Upward Bound Programs, recruiting Black students for college enrollment, or other volunteer or paid summer work, in the mental health field.

It is only in the recent past that special efforts such as those described above have been available to Black youth, augmented by materials that describe job opportunities, salaries, and employment settings in the professional and non-professional mental health vocations; the training required information on scholarships, and summer work placements. The challenge is not just simply to open channels of information to job opportunities, but to stimulate and motivate youth to see such opportunities as relevant to themselves through a live experience in a work setting.

A second program was a demonstration project coordinated by MAMH staff and chapter representatives (two social workers, consultants to the project) with ABCD (Action for Boston Community Development) and Boston State Hospital, Nursing Division. The purpose of the program was to train youths (school drop-outs) recruited from Neighborhood Youth Corps Centers (ABCD) as hospital attendants and nursing aides. If such youth were sufficiently motivated and had the potential, they would be encouraged to achieve work training to their optimum capacity.

The plan included 32 weeks of training and orientation by hospital nursing staff with provision for an educational component (work toward high school accreditation) at Northeastern University to be included. The youths would be paid \$1.25 per hour for an eight-hour day, five days a week, budgeted by OEO funds through ABCD. The goal was to help them gain

skills in a mental health vocation, in order to hold paid jobs.

Young adults were carefully screened by counselors at the centers, interviewed by supervisory nursing staff at the hospital and, after setting up schedules to accommodate training, orientation and compensatory education, were assigned to hospital staff on an individual basis. MAMH provided funding for uniforms and other necessities through a special grant.

Evaluation sessions were called periodically by MAMH staff and representatives of the chapter together with the cooperating agencies, in order to work through some of the problems. For example, hospital staff pointed out that such youths required a great deal of support, encouragement and understanding if they were to continue to function in the program. Staff said that

with the school drop-out program one was working with symptoms; that "the time and energy it requires to make this program productive, might better be spent improving the public school situation or working on other causative factors."

The third program developed from interest reflected by residents in a large housing project—to provide mental health education for teachers in a school district close to the project.

Because of tensions between the community and the Boston School Administration, it was recommended that MAMH staff negotiate the contract for in-service training with the department of curriculum development at the central office.*

In the interim, the principal and assistant principal of the school were contacted and, at their suggestion, content of

Later evaluation . . . reflected the feeling that . . . one was working with symptoms, that "the time and energy it requires to make this program productive, might better be spent improving the public school situation or working on other causative factors."

changing youth's attitude toward work was basic to their availability as trainees. Three thirty-two week sessions were completed. Several of the youths were employed by Boston State Hospital as attendants; others went into paid jobs that provided time off for further training, such as certification as licensed practical nurses. One student, given assistance in securing a scholarship, was planning on attending college to prepare as a registered nurse.

The demonstration project closed after completion of the third series, due to uncertainty about continued funding through OEO and change in the administrative staff of the hospital nursing service.

Later evaluation on the part of other chapter members reflected the feeling that

the course, sensitivity training, was discussed with a representative group of school faculty. The principal, adjustment counselor and a guidance worker were members of the Fort Hill Chapter, and not only were they included in the planning, but were a sounding board for faculty interest.

Three groups were organized, fifteen teachers in a group, each group representing grade levels from elementary through junior high, including special school personnel.

Because this was an experimental program and differed from the traditional lecture course, eight two-hour weekly sessions

* The contract stipulated: the content of training, the dates scheduled for the series; fees for the psychiatric faculty.

were planned with the option, which was taken, to continue for four more weeks.

Psychiatric faculty was recruited through the Department Head of Boston University Comprehensive Mental Health Center.

Final evaluations by the teachers contained the following recommendations:

- A. That continuing individual and/or group consultation be available to the faculty,
- B. That a similar program be set up for parents and teachers combined,
- C. That Group Process oriented sessions be available for administrators.

An abstract of the evaluations was formulated by the school principal and presented at the Chapter's board meeting when special emphasis was directed toward mental health education for parents.

An indirect but important development from the first experimental mental health teacher training program in the inner city was the action taken by the school administration to arrange psychiatric consultation on the administrative level with the Laboratory of Community Psychiatry for the immediate future. Long range plans are in the formative planning stage for utilization of psychiatric staff from comprehensive centers to be available to the teachers as consultants.

Other programs have been developed:

- * The Social Club, a social rehabilitation program for the returned patient supervised by a social worker. This activity was planned, organized, and continues to be administered by community volunteers.
- * Summer school classes requested by the chapter from the Boston School Administration for emotionally disturbed children in special classes during the school year.

- * Demonstration program for pre-school emotionally disturbed children—funds have been requested from the Regional Mental Health Council.

Chapter members have conferred with the Governor and legislators in support of the capital construction funds for the new comprehensive mental health center; they were active in the establishment of a Comprehensive Health Center in the Community; their role as catalysts for training grants to be utilized to train non-degree people in the community as staff to provide mental health services was outstanding.

Demonstration programs can facilitate the organization of a chapter; can provide a testing ground for ideas; can help focus the purposes and goals of a citizens organization.

However, paying attention to the quality of the processes of community organization; i.e., how people are involved in the planning, how they are involved in the decision-making process, to what degree self-determination is encouraged can help or deter vital community efforts.

The mental health worker can enhance the quality of the community organization processes by being responsive to the community's concerns, by supporting and cultivating the initiative and talents of community leaders, by bringing information, by being a resource. In turn, because this is an educational and reciprocal process, citizens themselves become mental health resources and community leaders.

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The Mental Hospital Patient-Consumer as a Determinant of Services

While change is a much vaunted value in our society, it tends to exist more in the mind of the power structure than in actual practice. The author suggests that change must be built into the mental hospital system by providing a power base for patients. Operating on the principles of the consumer-producer relationship, patients can control the quality of services they receive. The negotiating process itself can also be therapeutic for the patient-consumer.

The terms "change" and "innovation" are highly prized in our new-fashioned society and are becoming equally prized in the society of our old fashioned mental institutions. But are our mental institutions really changing?

The thesis of this paper is that while changes have occurred, the degree and rate of change are far from acceptable and that we are still laboring under the myth of great mental hospital changes. Furthermore, it will be argued that the process of change will remain a myth as long as certain present and basic circumstances exist.

Whatever new and wonderful things are

available to the patients is to a great extent a function of the staff's commitment to these things and its paternalistic benevolence. This is why the 8:00 A.M. to 5:00 P.M. weekday milieu is often distinctly different from the other time periods. This is when the benevolence of staff—or, more correctly, benevolent staff—is more present. When a patient can be some staff person's patient in a clearly responsibility demanding manner, he is more assured of the staff benevolence. He is not completely more assured, since benevolence is often periodic and subject to many factors extraneous to the staff-patient setting. Christmas, other holidays, pre- and post-vacation periods, among a multitude of things, affect the nature and quality of benevolence. How often one has heard a staff person say to a patient in response to some request "Wait until I

Dr. Ishiyama is Chief of Special Services at Cleveland State Hospital, 4455 Turney Road, Cleveland, Ohio 44105. He is also an associate in psychology at Case Western Reserve University.

To the extent that there is a benevolent staff and the benevolence is not overly taxing, the patient will benefit. Therefore, attempts to acquire more benevolent staff are made by hospital administrators. Unfortunately the high staff-patient ratio approach is extremely expensive and unrealistic in view of the limited supply of spontaneously benevolent persons.

return from vacation," or "I just returned from vacation, so wait until I get back into the swing of things again." Worse is "Let me think about it," a statement which leaves the patient at the mercy of the often deliberate and spotty thinking processes of the staff.

To the extent that there is a benevolent staff and the benevolence is not overly taxing, the patient will benefit. Therefore, attempts to acquire more benevolent staff are made by hospital administrators. Unfortunately the high staff-patient ratio approach is extremely expensive and unrealistic in view of the limited supply of spontaneously benevolent persons.

Why is it that those who are supposed to benefit from the changes—the patients—are so often at the mercy of the whims and rationalizations of those who dispense the fruits of the changes?

I would suggest that the changes have not been real because they have been only in the minds of the changers and not in the basic operating system. There are no systematized demands for improvements built into the mental hospital. The pressure to change, to improve, is only in the minds of the staff and therefore subject to the whims

of those minds. Why is industry able to generate so much sustained and almost routine progress and change while progress in mental health has to be so laborious and slow, accompanied by agonizing reappraisals and discussions and painful sensitization sessions?

The demand for change, progress and improvements in industry is built into the nature of the producer-consumer relationship. The relationship is one of bilateral negotiations, with the consumer demanding that he get the best product for his money. The ultimate condition for continued success in a competitive field is that the product be reasonably close to being the best for the price. The built-in quality control is the consumer.

In the field of mental health, particularly in the public institutions, the situation of bilateral negotiations seldom exists. In the first place, the mental health field is not a competitive one. The shortage of professional mental healthers is so acute that even in the private sector a monopoly is the reality. In the public institutions a closed service system exists so that the receiver of the treatment services has absolutely no formal and only limited informal ways to determine from whom he receives those services. Second, the receiver of the treatment services is less a consumer than a product. Whatever lip service is paid to the notion that the patient is the recipient of treatment services, in the mental health field the patient is treated as if he were a product gone bad and therefore in need of repair. If I have a broken leg, I as the recipient of services expect to have the product—the broken leg—mended. I am the consumer, and therefore have a say as to how and from whom I receive service. But if I am the object in need of repair, and this fact is legitimized by the legal apparatus, who is the consumer? Can I be both the

consumer and the product? In the public mental institutions, it is clear that the patient is not the consumer. The prerogatives of a consumer are not his. The patient has no choice as to what treatment he will receive or whether he will receive treatment. He has no choice as to the dispenser of that treatment. He has no way of participating in the decisions which affect him because he does not even have the power base that goes with monetary payment or the withholding of payment.

If the patient is not permitted to play the role of the consumer, who assumes that role? It is the public. It is the public that hires the treaters; it is the public that allows the treatment procedures. Unlike the individual consumer, the public-consumer does not assume a direct interest in the quality of the treatment services being dispensed in accordance to its interest, or more accurately, its disinterest. Very often the only service in which the public seems to be interested is the containment of the product—the patient. What has resulted is a near conspiratorial relationship between the hospital and the community against the patient. Community groups associated with

that consumer—at least to the extent that consumer demands answers. The consumer, historically, has demanded answers when the hospital fails in its jailing and custodial functions. Outcries of indignation are heard when miserable physical conditions are bared; outcries of concern are heard when a “former mental patient” who presumably has been released too early commits an act of aggression. These outcries are only periodic and short-lived, however. Seldom heard are outcries of indignation for the prolonged detention—twenty, thirty, forty years—of patients. And since the consumer cries out only when there is “trouble,” the hospital’s orientation becomes one of avoiding trouble. The staff’s fear of being sued becomes spelled out in terms of being afraid of doing something, because there is little fear of being sued for doing nothing.

A great deal of activity has been generated recently to change the conspiracy by aroused, sensitized and concerned persons, both on mental hospital staffs and in the public. The activities of concerned hospital staff members have centered around efforts to sensitize themselves to the needs

There are no systematized demands for improvements built into the mental hospital.

the mental hospital are almost totally organized to help staff vis-à-vis patients rather than to help patients vis-à-vis staff.

The foregoing picture is becoming modified to some extent as segments of the public become more interested in the civil rights of patients and the patients’ right to treatment. In the main, however, a dismal picture is the usual and prevalent one.

The Community as Consumer

Since the community-public is defined as the consumer, the hospital is answerable to

of the patients and to become aware of dehumanizing practices in the hospital. The activities of concerned community members have also centered around efforts to have the hospital system become aware of the needs and rights of the patients. While both are commendable, they each have insurmountable drawbacks. The attempt to create a good and sensitive staff with good skills and good intents is useful and effective only up to a certain point. I am convinced that any upgrading in staff functioning which is dependent entirely upon the staff’s

self-started goodness and purity of heart is doomed to a short life. There will be fade-out, burn-out, cop-out and plateauing! Furthermore the upgrading will be slow, overly deliberate, not maximal and essentially paternal.

The concern of some segments of the public for the patient is made less impactful because of the simple distance between the two. The concern for the civil rights of the patient, for instance, may be focused on a narrow object—the test case—or it may be so generalized to all patients that no patient benefits. Again the concern is limited, periodic and distant.

How, then, can the public mental hospital system be changed so that necessary and humane improvements, long overdue, can occur? What kinds of systemic changes must be wrought? One might advocate the elimination of the mental hospital. This may be the only true solution, but we do not as yet have any evidence to indicate that such a solution is the present best one. Let us for the moment assume a mental hospital is useful and necessary as an institution. Then one issue becomes that of making that institution an institution maximally responsive to its clients.

I believe that the most effective way to do so is to change the nature of the power system. All mental hospitals have been closed power systems. It has been assumed that all power resides in the superintendent and that power was then sometimes distributed along a hierarchy, but the distribution could always be rescinded or withdrawn. In this kind of system, the lower echelon people could only have power given by the higher-ups. In such a closed system, paternalism and fiatmanship flourish.

What would happen if we begin to see the mental hospital as an open or expanding power system? Then we can begin to see that any element of the system can increase

its power without sucking on some other element's power base. In an expanding power economy, the economics allow for an expanded base for all, since we are no longer viewing power as a relatively scarce commodity over which the various parties contend in terms of some conflict of interests. After all, we can all agree that all elements in a mental hospital share, or ought to share, a clear mutuality of interests—the accruing of benefits to the patient. Secondly, there is reason to believe that as all elements of an organization increase their share of the power, they can generate joint power as the result of more effective command of the organizational resources.

A basic system change must, I believe, involve defining the patient as the consumer, instead of as the product-to-be-mended. This then means that the natural supplier-consumer relationship will ensue.

No longer will the patient be as victimized by the paternalism of the staff and the rare and the absentee consumership of the

Aren't most patients capable of deciding whether they want or don't want a bed to sleep in? Most patients are capable of negotiating for something.

public. This means that the patient-consumer can begin to place demands upon the staff-supplier. This means that the patient can then have a power base from which he can negotiate for services. Negotiations replace fiatmanship and self-determinism rather than paternalism becomes the desired condition. Care then is not dispensed but negotiated. Treatment may then become more than the goods exchanged, perhaps the exchange process itself.

Building a Power Base

Granted for the moment that the patient-as-the-consumer notion may be a good one, how can the patient in a public mental institution assume the consumer role? After all, he does not have the source of power that is more available to the patient in private medical or mental hospital settings—the payment base. He is very often a legally committed person without the basis of his civil and legal rights. He may, as so many mental health experts are quick to point out, be without the socially acceptable power base of rationality and ability to meaningfully interact with his environment.

The assumption of any role is dependent upon not only the desire and ability to assume that role but also upon the availability of that role. Therefore, a milieu must be established in which the patient-as-a-consumer role is a rational, consistent and acceptable one, and then the patient must be given all the help he needs to assume as much of the consumer role as he can.

A consumer exerts power—can get the most for his money—when there is some competition for his money. That is, there must not be a monopoly. In the usual public mental hospital, neither competition nor payment exist to enhance the patient's power to negotiate for services. He is assigned to a doctor, or a ward, until the doctor or ward no longer wish to serve him for whatever positive or negative reasons. Very often the assignment is such that the patient may, in fact, serve the ward. In any event, the patient cannot choose from whom and where he receives or does not receive services let alone determine what services he will receive.

What would happen if, at the earliest reasonable moment, the patient were given

the option of selecting the staff from whom he would receive services? While reality might declare that the pool of staff from which the patient could select would be limited, he would have at least one more option than he has now. It might also mean that as certain desirable (from the patient's point of view) staff members accumulated a maximum number of clients, they would become unavailable.

Community groups associated with the mental hospital are almost totally organized to help staff vis-a-vis patients rather than to help patients vis-a-vis staff.

Would establishing such a procedure lead to the development of useful and effective processes? What gains would ensue?

I believe that the institution, the staff, and the patients will all derive benefits. Bureaucracy will be reduced. No longer will an overloaded supervisory bureaucracy be needed, since supervision will be built in.

The public mental hospital will become less a refuge for incompetent and/or inactive staff persons. The demand for competence and service will come from the consumers and will be an integral part of the system. The maximum can be derived from the existing staff so that services can be increased through more efficient utilization of existing resources and not by spiraling expenditures. Work will be measured not in terms of hours or of number and quality of written reports, but by client demand. Those who do not have the maximum clientele will have to become more active in developing the delivery of meaningful services, so that the clientele is maximized.

The assumption of any role is dependent upon the availability of that role. A milieu must be established in which the patient-as-a-consumer role is a rational, consistent and acceptable one.

The staff will also participate in the benefits. For staff, a new system of rewards will ensue. What will be rewarded will be initiative and responsibility, and the rewarder will not be a vague, distant and often inaccessible superintendent but the close and ever present client. The staff member can now spend less time in proving his competence by becoming an expert report writer or an articulate discussant, and more time in sharpening and improving his ability to be of value to his clients. Furthermore, since the consumer becomes a kind of supervisor-collaborator, there is no need for the degree of paranoia vis-a-vis administrators that staff members have maintained in the past. Administrators become coordinators and facilitators rather than supervisors.

The most significant benefits, however, should accrue to the patients. First of all, the patients will no longer be so vulnerable to the whims and incompetence of staff, since he no longer needs to be wedded to a staff person. The patient is, in effect, in a position of being a kind of supervisor. He no longer is the passive recipient of holy services dispensed by the omnipotent and omniscient, for he now assumes a more collaborative role—simply because he is and can view himself as being a worthy human being with powers of negotiation. Attempts to democratize the mental hospital in the past—such as patient governments—have taken the direction of incorporating democratic, negotiating principles into an exist-

ing, essentially non-democratic system. Thus the patient governments existed only so long as a benevolent staff permitted its existence. If the patient governments exist because the total hospital system decrees that they exist, then they can operate on a more effective basis. Such could not be the case in a basically non-negotiating pyramidal power structure which defined the patient as being non-equal, simply because he has nothing with which to negotiate. Patient governments usually are no more than expressions of a benevolent, static staff-patient relationship rather than a dynamic, negotiating, transactional relationship.

The negotiating process itself may be therapeutic and growth producing. Learning and executing the negotiating process will increase one's social and behaving armamentarium. Coping mechanisms are developed, with a concomitant increase in self-esteem and a decreased reliance on the dependent, child role. There ought to be an increase in the feelings of efficacy.

While a milieu in which the process of negotiations is enhanced may be advocated, it might be argued that bilateral negotiations will not occur, simply because so many patients do not have the wherewithal to participate meaningfully in the negotiating process. While I cannot argue away this contention, I do believe that far more patients have the ability to negotiate than have been credited. Most patients in mental hospitals have been thoroughly indoctrinated into the role of the quiet, accepting and non-demanding patient. They enter an institution where they can negotiate for nothing, including the medication which is prescribed for them and the beds they sleep in. What would happen if a patient were assigned to an empty room and he could then negotiate for all of the furniture, in-

cluding his bed?• Would he not be given the opportunity to structure his environment rather than having his environment structured by a force outside of him? Is this not the kind of thing that would encourage the sense of being responsible for and capable of determining one's fate? Aren't most patients capable of deciding whether they want or don't want a bed to sleep in? Most patients are capable of negotiating for something, and our notion that patients are incapable of negotiating results from our own perceptual and conceptual narrowness.

Advocacy System

While the foregoing argument may be valid for many patients, there are still others who probably cannot make the first move to negotiate, unless there is a staff which not only allows but encourages negotiations. These patients need support in learning the experience of negotiating. And since they cannot wait for staff to learn leisurely to allow negotiation and they cannot always rely on staff's goodness and kindness, they need to be provided a source of

The negotiating process itself may be therapeutic and growth producing. Learning and executing the negotiating process will increase one's social and behaving armamentarium.

constant guidance and support. These patients need advocates. The usual ward or clinical staff are service providers and not patient advocates. At one time I thought that the psychiatric aides, because of their closer socio-economic and cultural affinity to patients, might assume the role of pa-

tient advocate, but as long as the aide's role was defined with a treatment-service orientation, the assumption of an advocate role was difficult.

While the establishment of patient advocates may take a number of forms, certain basic processes must be assured. First, the advocate must have a source of power which permits him to assume the advocacy against a staff person or a group of staff persons. A system can be established by having the advocates directly responsible to the highest authority possible, be it the hospital superintendent, the state director of institutions, or whatever. The point is that the advocate must have a meaningful and effective power base.

Second, it must be clearly spelled out that the advocate is in the "employ" of the patient. In this respect, the advocacy may take several forms. There may be occasions when the patient may need someone who has the skills to fight his battles, such as a lawyer. There may be occasions when the patient needs help only to the extent that the system does not respond to him, and the system needs to be nudged in the needed direction. There may be occasions when the patient only needs to know how to get to a negotiating table. The patient may need support and encouragement to even think about or perceive a need to get to the negotiating table. And, finally, the patient community may need to know how to redefine and to execute the rules and processes of negotiation.

In our hospital we are in the process of developing a three-pronged program designed to help the patient to acquire and to develop useful negotiating skills and powers. We have designated several new staff roles. The first, that of client orga-

• This interesting approach is being carried out in a special project conducted by Hicks and Lesyk at our hospital.

nizer, is aimed at stimulating the development of a more effectively negotiating patient community. Several rather basic methods are utilized. The initial effort is to make known to the patients that they have certain inalienable rights—one of which is the right to ask, to negotiate. The questions patients ask, ranging from "Why is my ward locked?" to "Why can't we have more cheese in the macaroni and cheese?" are published in the hospital newspaper. Patients are urged by the client organizer to raise questions. Handbills carrying admonitions such as "Negotiate," are widely and visibly distributed. Whenever a group of patients has a grievance to make, the organizer serves to support the group effort and to act as a group consultant. His task is to help the patient win and to work to insure against failure. He is to help the patients to organize to successfully deal with problems and issues. Every patient success is widely publicized in the hospital paper. The client organizer's task is not to raise issues nor to stimulate conflict, but to help the patients develop the skills and the group confidence to be able to negotiate effectively with their environment.

On other occasions, more individual negotiations must occur. A particular patient may be put off by the bureaucracy, so that services due him are significantly delayed or even denied. For such cases an ombudsman is provided. The ombudsman's task is to pressure the bureaucracy into carrying out, quickly and in a manner satisfactory to the patient, a service due the patient.

Both the ombudsman and the client organizer, in our program, derive their power from the superintendent. In effect, they are house watchdogs. To this extent, it is evident that their power is contingent upon the whims of the superintendent. The third prong, however, provides an extra-hospital

power base. This is the legal services provided by the Legal Aid Society, and available to all patients. Services of the LAS attorney not only take the form of patient advocacy but also patient protection.

The trio of patient advocates, with differing power sources but working in a coordinated manner, are to provide to the patient the support and the resources he needs to engage in the negotiating process. It is clear that the presence of patient advocates indicates that a hospital defines its task as serving its clients, and is willing to be monitored, both by itself and by outside forces, and to be responsive to its consumers.

Criticism of Plan

While the patient-as-a-consumer concept may sound all good and well, are there not some pitfalls? Let me now consider some of them.

Won't allowing the patients to participate in a free enterprise-like system which permits choosing their own servicemen result in a popularity contest, so that the servicemen will begin to dispense what the patients want, rather than what they need? Won't the patients then get services which may be momentarily pleasing, but not beneficial in the long run? While such possibilities do exist, there are a number of factors which decrease the possibility of such occurrences. First, there exists a certain amount of integrity on the part of the staff. Second, I am convinced that for most patients, the popular staff person is popular because he does consider the welfare of the patient to be the primary consideration. Finally, even if popularity is based on a friendly, momentary smile, a friendly, momentary smile may be a lot better than what usually goes on now!

Would not this system result in an overload on some members of the staff? Yes, and therefore certain safeguards must be built in. Staff persons ought to have the right to place upper limits. Obviously there must be a reasonable range of clientele. But I believe that a reasonable range will emerge and this range will be a negotiated and dynamic range, worked out multilaterally rather than unilaterally.

Won't the patients misuse their power? Misuse of power may result, but the point is that the absence of power, for the patient, is, in fact, a far greater travesty on justice and on the treatment process. As a matter of fact, learning how to mobilize and to use power may well be a part of the hoped for therapeutic process. Finally, one must remember that the power accruing to the patient is not monopolistic and is used in a setting of bilateral monopolies. The oppression of patient power is blunted by staff power, much as it is hoped that staff power is blunted by patient power. I think the reality of the mental hospital situation makes staff power a much more oppressive force than patient power.

Isn't the advocate system still paternalistic? In the strictest sense, the patients are being given the right to negotiate. How is this different from the patient government? Let us admit that paternalism and autocracy can be read into most situations. Our intent is to decrease authoritarianism and paternalism. The intent is to set up a series of relative guarantees so that the right of patients to negotiate cannot be

summarily and quickly revoked by a person or group of persons.

The staff, doctors, the aides, etc., becomes the aide of the patient-consumer. The staff becomes helpers rather than controllers or dispensers of favors.

In summary, then, the intent of the restructuring of the staff-patient relationship is to develop a negotiating, relatively self-deterministic, growth enhancing, dynamic milieu. The restructuring ought to allow all segments to have a growing power base and to prevent the oppressive situation in which the weak must docilely fit into that which is mandated by the strong. This paper merely presents one possible method of achieving this goal. Details are deliberately left vague, because the actual institution of even the suggested model would have to recognize local issues and peculiarities.

I would like to add one final note. The ever-growing enthusiasm for community mental health activities is commendable. But what happens when the enthusiastic period is over and the nitty-gritty routine sets in? Will the community clients, many of whom are not paying clients, become like the present non-paying clinic and hospital clients? As long as our enthusiasm is paternalistic in nature, won't the paternalism eventually become stifling, restricting, and selective? How can we set up a negotiating community program? How can we avoid the monopolistic trap? We need to find some answers if we are to prevent the development of the old state hospital-type cultures in the community settings.

Leonard C. Suchotliff, Ph.D.

George J. Steinfeld, Ph.D.

Gerald Tolchin, Ph.D.

The Struggle for Patients' Rights in a State Hospital

The authors present a case history of a conflict between the administration of a state hospital and staff and community groups in regards to patients' rights. They conclude that change can only be brought about when the community, which is being "protected" from the mentally ill, realizes the discrepancy between the ideal of treatment goals and the reality of the custodial system.

Introduction

This paper will describe some of the events that took place as we addressed ourselves to the issue of patients' rights and the dehumanizing conditions in one of our "better" state hospitals in Connecticut. It will then attempt to discuss the reasons why these problems were allowed to exist unchallenged and the issues which arose when we tried to change things by con-

fronting the mental health establishment. Finally, it will offer recommendations which we believe can help to close the gap between ideal mental health principles and what politics, expediency, and safety dictate to our mental health leaders.

Summary of Events

Although we had been aware of hospital conditions for some time, in early 1968 the authors and other members of the psychology department of a large Connecticut state

Dr. Suchotliff is a clinical psychologist at Fairfield Hills Hospital, Newtown, Connecticut; Drs. Steinfeld and Tolchin were formerly clinical psychologists at Fairfield Hills Hospital. Dr. Steinfeld is currently the Research Director at Clifford Beers Child Guidance Clinic, New Haven, Connecticut. Dr. Tolchin is Assistant Professor of Psychology, Southern Connecticut State College, New Haven, Connecticut.

The views here expressed are those of the authors and do not necessarily reflect those of the agencies with which they were, or are now, associated. This paper covers the time period until October, 1969. As of November, 1969, a new Superintendent was appointed.

hospital became extremely interested in the issue of patients' rights in its legal and moral sense. In the course of our work at the hospital it had become clear to us that patients' rights were frequently violated. We discovered that: (1) patients were often not permitted to contact their attorneys by phone or mail; (2) persons in the hospital on informal or voluntary admission (status) were sometimes kept from leaving even though they were legally permitted to do so; (3) patients who were being probated (legally committed to the hospital for an undetermined time) neither knew of their right to contact their own attorney or physician to contest the procedure, nor were they given free access to the phones or mail if they were aware of their rights. In addition, probated persons often did not have their cases reviewed; (4) informal and voluntary patients who left the hospital without informing the administration were coerced into returning (i.e., forcibly taken back after being chased by hospital staff) even though they were legally entitled to leave any time they wished. On another level, we became aware of the work of Szasz,² Goffman,¹ and Vail⁴ on the effects of dehumanization and institutionalization, and we began to question hospital policy and practices in regard to whether they adequately protected the legal and civil rights of patients, as well as their dignity and self respect.

After a few months . . . we came to realize that the committee was a sham.

Confronted with what we considered were gross violations, we addressed ourselves to aspects of the problem by supplying information to patients who questioned us about their rights. We offered names of agencies where legal assistance could be secured, i.e., Legal Aid Society, the Con-

necticut Civil Liberties Union, and local agencies and attorneys. We also tried to improve the physical environment of the wards, attempted to get patients more involved in decisions concerning their own treatment, mailed letters for patients when we had evidence that mail was being censored, and tried other activities designed to protect the welfare of patients. As a result of our activities, patients did write to attorneys and word of what we were doing spread to the hospital staff and to the administration. Although we believed that we were acting on behalf of patients, and therefore in accord with our personal and professional ethics, some of the administration* did not agree. The administration asked for the resignation of the three psychologists who were engaging in these activities.

In an effort to lessen the tension that had been created between the hospital administration and us by virtue of our taking an advocacy role, we met with the State Coordinator of Psychological Services. He was brought in to act as a group consultant to help clarify the nature of the conflicts that existed in our department around the issue of patient and staff rights. As a result of these meetings the request for our resignation was withdrawn contingent upon our agreement not to pursue the issue of patients' rights within the hospital setting. As an alternative we were encouraged to

work for change on our own time, and in conjunction with the local mental health association.

After about six months of study and dis-

* The word administration is used as a general term for all persons in the hierarchy, except those specifically mentioned.

cussion with interested members of the community, and the Connecticut Association for Mental Health, two of us worked up a patients' Bill of Rights which was introduced into the legislature. The Connecticut Association for Mental Health submitted a bill, also. When both bills came up for public hearings, we were requested by the Representative who sponsored one of the bills to testify in open hearings in support of them, which we did. As a result of our testimony in early 1969, which reached the newspapers, the Superintendent withdrew our application for convention funds, even though both of us were scheduled to present scientific papers, and customary state and hospital policy provided expenses for staff members who are part of the convention program. The Superintendent told us that the withdrawal of funds was in retaliation for our "disloyal activities" (going outside the system and testifying). He seemed to interpret working for the hospital as being synonymous with losing our rights as citizens. It should be noted that our access to the Superintendent was blocked by a department policy which forbade us to contact the Superintendent directly and we did not wish to risk charges of insubordination. Thus, we did not have the opportunity to inform him of our plans prior to testifying.

On the other hand, as a result of our meetings with the Superintendent, an important change was introduced into the hospital. The Superintendent agreed with our request to establish a Hospital Advisory Committee, with one of us as chairman, to deal with questions regarding the type and adequacy of treatment offered, the legal aspects of hospitalization, and the dehumanizing conditions which existed at the hospital.

This committee made two sets of recommendations, one having to do with seclu-

sion room practices, and one dealing with changes in the physical aspects of the ward environment, and personal grooming; i.e., quality of mirrors, toilet facilities, personal possessions, clothing, etc. Of these recommendations, only one (dealing with the purchasing of clothing) was acted upon. For a number of months we acted with constraint, wanting to give the committee and the Superintendent a chance to meaningfully deal with questionable hospital practices. In our discussions with community people, we supported the Superintendent and his attempts to do something about patients' rights by establishing this committee. After a few months, however, it became clear that the committee's recommendations would not be acted upon by the Superintendent and we came to realize that the committee was actually a sham.

The next issue of which we became aware was that there appeared to be some irregularities regarding physicians who examined patients for the probate court. That is, contrary to what appears in the state statutes, these physicians were "connected" with the hospital. We brought the problem to the attention of the Superintendent, who advised us to discuss the matter with the probate judge. We did and within four days our resignations were requested for the second time. It should be noted that at about this time two petitions circulated by other hospital employees, containing allegations of patient mistreatment and racial discrimination, became public. The administration indicated to us that they believed we had collaborated with the petitioners. This "connection", based on our sitting with the employees at breakfast, was unfounded. In fact, when we learned of the existence of the petition we recommended that they bring the allegations before the Hospital Advisory Committee.

It should also be mentioned that infringe-

ments on academic freedom took place. One of us sent the Superintendent a copy of a paper entitled, "Parallels between the pathological family and the mental hospital: a search for a process." The Superintendent withdrew permission to attend a summer institute. The paper was subsequently accepted for publication by a professional journal although the Superintendent would not grant permission to have the hospital's name appear on it. Prior to this, a newsletter, edited by a staff psychologist and intended for distribution throughout the state was not permitted publication through regular hospital channels because it dealt with issues of patients' rights. Further, the administration issued a memorandum stating that all mail which was to be stamped by the hospital would have to be sent opened. This was a new practice, to our knowledge, and the intent appeared to be that of censorship and intimidation.

In the summer of 1969, some other forms of intimidation took place. These involved the interruption and undermining of several treatment and research programs which were under our supervision. In one case, the removal of two staff members along with other acts of harassment led to the collapse of a major treatment program. Finally, in July of 1969 we were requested to cease all our clinical activities (work related to patients) as of September 1, 1969, with no explanation given. Although we believed that the restrictions in our activities were attempts at harassment by the administration in order to get us to leave the hospital because of our activities, our evidence was circumstantial. However, our impressions gained additional support when we examined the hospital's Board of Trustee minutes of a meeting held at the end of May, 1969 in which it was stated that we were asked to resign because of our patients' rights activities.

Prior to September 1, 1969, however, a series of articles appeared in the local newspaper describing the deplorable conditions at the hospital, the forms of staff intimidation that were taking place, and the power struggles between various members and organizations in the mental health bureaucracy. The series was initiated by the executive editor of the newspaper who was also a board member of the local mental health association.

As a result of the public's response to this series, along with the urging of the state mental health association, which had accumulated several case histories of violations, and of ex-hospital employees, concerned civil and professional groups, and key political figures, the governor called for an investigation to be conducted by an independent "Task Force" of mental health professionals not connected with the state. Two previous investigations of the hospital earlier in the year had been carried out by state agencies, i.e., the state police and the Human Rights and Opportunities Commission. Both produced negative findings around the charges of brutality to patients and racial discrimination against Black employees. It was argued by us, and others, that at that time these investigations missed the essential heart of the problems, namely, questionable administrative and patient care practices. The governor's calling for another, more complete investigation, conducted by an independent non-state affiliated group of mental health professionals, rectified this.

Immediately after the announcement of the investigation, the administration began to institute some changes. Beds were moved from buildings, patients were transferred and released from the hospital with inadequate preparation, briefcases were provided with locks to guarantee the confidentiality of records being transported between build-

ings, flagpoles were painted, and contact was made with several community agencies to discuss halfway houses and other programs that the hospital rejected earlier when proposed by the local mental health associations.

We discovered that the hospital acted as if its primary client was not the patient, but the family, or community agencies.

In early October of 1969, the Superintendent submitted his resignation. The reason publicly given was that he was stepping down for a younger man. It would appear, however, that he was under a great deal of pressure to resign. With the resignation of the Superintendent and the investigation, changes were swift in coming. Several key persons at that hospital who were sitting on the fence started taking steps toward us. The request for our resignation was withdrawn; we were reinstated completely; it was admitted that decisions were hasty and inappropriate, and we were asked to stay to help rebuild the department. Departments, previously fragmented, were asked to unite in an effort to help the new Superintendent institute programs that were intended to raise the level of treatment for the patients and make the hospital an effective vital facility in the state.

Reflections

The Nature of the Client

In the course of our activities, we discovered that the hospital acted as if its primary client was not the patient, but the family, or community agencies. We learned that the needs of the community were often quite at variance with those of the patient. The primary need of the community is frequently not treatment and rehabilitation

for the patient, but his containment, i.e., its first wish is to remove the source of irritation. Labeling a person as mentally ill is an effective way of controlling him. The acceptance of this type of contract with the community by high level administrators, and thus, the hospital, leads to the imposition of restrictions upon the patients' legal and civil rights. Patients' demands for constitutional guarantees and treatment which measure up to accepted standards of decency can be ignored by the establishment since the patient is not the hospital's primary client and the patient's demands for his full constitutional rights conflict with the hospital's secretly mandated goal of containment, which, of course, is at variance with its publicly stated goals.

One need not consider those who occupy high administrative positions in such a system to be ogres in the sense that they are overtly malicious. It is just that they serve a client other than the inmates, and hence, will be reluctant to take action which is not sanctioned, or mandated by the community, or those in still higher positions. To take a position of advocacy for the patient would be to bring the administration in conflict with the power structure, and therefore jeopardize its position.

Our sense of uneasiness with the existing system was a function of essentially one basic, and rather naïve, consideration, namely, we defined our client as the patient, and not the hospital or the community. Once we did this we could not avoid confronting the fact that the hospital and the community were continually violating their stated ideal, that the goal of incarceration is treatment, and that release is determined by: (a) the patient's behavior; (b) whether he could benefit from further hospitalization. It may be that since we were administratively powerless, or felt our-

selves to be, and thus alienated from the existing system, it was easier for us to define the patient as our client. Regardless of why, once we identified with the patient, we were confronted with the discrepancy between the mental health ideal, and what was politically real.

Our response to this experience was to make a decision to attempt to alter the existing reality. To passively accept what we viewed as deprivations of legal and civil rights of patients would not have been acting in accord with our personal and professional ethics which demand that we act so as to protect the dignity and welfare of our clients, even when conflicts of interest arise. Equally important, and perhaps at the basis of our attempt to change the system, was the anguish we experienced when we asked ourselves the simple question, "Would you like it to happen to you?"

Establishment Techniques to Handle Dissent

Our conflict with the administration was peculiar, since the latter was never able to openly disagree with what we were saying. This was because what we were asking for

"If you are going to fight for the rights of others, be prepared to fight for your rights as well."

was consistent with the verbalized mental health ideal. After all, no respectable administration could take a position against patients' rights and better treatment. Their disagreements with us had to be couched in a different idiom, and took form in terms of attempts at personal discreditation, i.e., our judgment, morals, and professional role and competency were questioned.

In general, the establishment attempts to deal with those who come to the aid of the

underprivileged or powerless groups by challenging the rights of the dissenters in the same way it challenges the rights of the group the dissenters are defending. This principle might be stated as follows: "If you are going to fight for the rights of others, be prepared to fight for your rights as well." This technique is necessary because when one appeals to the stated ideal in an effort to change existing practices the establishment, which wants to maintain the status quo, cannot present rational arguments against this position. Instead, it must deflect attention from the crucial issue and try to silence critics in other ways. What follows is a discussion of the means used by the mental health establishment to deal with dissonant forces.

1. The Big Threat-Small Compromise Technique

The establishment threatens to, or actually does, impose severe punitive penalties on the dissenters, e.g., persons are threatened with change in assignment or even loss of job, etc. They then offer to remove or modify these threats if the dissenters will consider stopping the questioning of existing practices. In short, they create a side issue which changes the focus from the original issue (in our case, patients' rights) to a struggle around the latter issues. Dissenters who may not be willing to compromise must then fight their battle on two fronts—the original issue as well as attempting to defend their right to raise these issues.

2. The Disloyalty to the Team Argument

One of the justifications given by the administration for asking us to resign was that we were "not part of the team". The definition of team work and loyalty seems to be narrowly defined in terms of "not

embarrassing the existing system by pointing out the discrepancy between the real and the ideal", or "not embarrassing the

... the easiest thing for the establishment to say is that there are really no issues, merely power politics.

reality sponsored by the team". This concept appears very much akin to the techniques of propaganda where the reality of any given event is defined as good or bad, not in accordance with scientific or moral principles, but in accordance with how well it fits into the prevailing ideological doctrine expounded by those in power. The dangerous aspect of the accusation of disloyalty is that it is by and large accepted by members of the system since they, too, would be embarrassed if the socially agreed upon definition of the hospital as an institution for treatment and rehabilitation were exposed. In other words, the disloyalty argument effectively suppresses dissent by many members of the establishment, and also serves to ostracize critics of the administration from the mainstream of activity within the system.

In response to this argument we were confronted with the question of what it means to be loyal? Loyal to whom or to what? We felt our loyalty was to the espoused mental health principles, our personal and professional ethics, and ultimately to the patients and the hospital. We repudiated the kind of blind loyalty which meant simply supporting the existing structure even if we disagreed with it. We believe that one must always act as a free agent, making decisions for one's self, guided by one's personal and professional code of acceptable behavior, together with utilizing the appropriate channels to bring about change. The disloyalty argument used by

the mental health establishment directly parallels that used by the present political administration in its attempt to stifle dissent. The existing administration generally equates dissent with disloyalty. We believe, on the contrary, that one must constantly ask himself, "To what am I being loyal when I take this position; is it to an established administrative structure simple because it exists, and has power; or is it to a system which has relevance to one's personal convictions related to specific issues."

3. The Personal Ambition Argument

Another way that the establishment attempts to deflect arguments from basic issues is to say that there are really no issues at all; what the dissenters really want is power. In this regard, our efforts to change the system were interpreted as an attempt by psychologists to wrest administrative control from the hands of the physicians; the patients' rights issue being seen as a red herring used in the power play.

From our point of view, the easiest thing for the establishment to say is that there are really no issues, merely power politics. Of course issues of power are involved; they always are when a group wants to change existing policy. It is simplistic, however, to interpret the wish for change merely as a means of getting others to do what you want independent of the issues involved. To say that confrontation is only a power struggle also rings of condescension, since the implication is that the need to confront is a neurotic manifestation of unconscious and unresolved conflict. When looked at closely, this argument implies that the dissenter is "sick", and need not be listened to, a process which parallels the administration's justification for ignoring the pleas of patients.

In summary, limiting the definition of the issue to power is not only near-sighted and banal, but serves as an easy cop-out which permits the existing structure to maintain itself unmodified by not having to listen to the arguments raised.

4. The Myth of Channels

One of the administration's favorite arguments in its attempt to discredit its critics was that "they did not go through the appropriate channels in their attempt to bring about change." Technically, they were correct. However, the administration neglected to consider the facts that: (a) access to the Superintendent was blocked for a long while; and (b) administrators high in the mental health hierarchy in the state knew about the existing conditions at our hospital for a number of years. They chose to ignore the information brought to light by concerned citizens and the mental health associations.

Further, when we did go through channels, we were given a lot of head motion, (a vigorous shaking of the head in a vertical direction, together with the clicking of the tongue) but no action. It also appears that channels are used by administrators as a way of passing the buck to those above and below them in the hierarchy. Even though we consider the channels lament to be an attempt to discredit dissenters, and deflect them from the basic issues, we would suggest that channels be used when possible, in order to be certain in each case that they are not a myth.

Recommendations for Social Action

Through bitter experience we learned that our administrator's desire for change could be motivated primarily by the application of pressure, and only secondarily

by an appeal to reason and morality. It is our contention that one effective way to bring pressure to bear on the system is by directly pointing out the discrepancy between the mental health ideal and what is the political reality. What follows are several suggestions for social action which can take place both within the system and by gathering support from the outside.

1. Appealing to the Discrepancy Between the Ideal and the Real.

a. Appealing within the system: The first step is to go through the existing channels in order to "give the system a chance" and to short circuit the criticism that one has acted impulsively and not given the system an opportunity to correct itself. When going through channels, one must beware of "tokenism", where the establishment attempts to alter its policy just enough to make it appear that it is sincerely interested in changing. When responding to offers which appear to be tokens, we recommend the following: Accept whatever the system offers, be clear about the objective you wish to reach and set a time limit for reaching your goals utilizing the existing structure. In short, we suggest that the minimal conditions for meaningful reform must be operationally defined, and a time limit set in which this is to occur. Thus, we may define "tokenism" in terms of the unfulfilled promise with which the establishment can be confronted at a later date.

In the course of our struggles, we found that the establishment was willing to address itself to the issues only when they: (1) saw us as willing to go outside the system; or (2) saw that we had already gone outside the system and wanted to prevent us from going further. However, their response even in these cases was "tokenism".

In short, our efforts to go through channels were ineffectual when we merely pointed out the discrepancy between the ideal and the real on a rational basis, so we enlisted the support of persons outside the system.

b. **Appealing outside the system:** The time to go outside the system is when tokenism is clearly apparent. When one seeks allies outside the system he must be prepared for very adverse consequences since at the point where the issues are made public the battle lines are drawn. There is no chance now for tokenism. It is change or maintain the status quo. The allies we solicited, and who solicited us were: (1) the state and local mental health associations; (2) private citizens within the community; (3) dissonant members of the hospital staff; (4) patients; (5) sympathetic members of the mental health professions; (6) legislators; (7) the Connecticut Civil

It is intriguing, and somewhat paradoxical, that our victory was finally obtained by appealing to the very constituency which the hospital considered its client, i.e., the community.

Liberties Union; (8) perhaps most important, the newspaper. In short, we allied ourselves with individuals and organizations who, by virtue of being respectable members of the community, could convey to the general community the existing discrepancy between the ideal and the real.

It is intriguing, and somewhat paradoxical, that our victory was finally obtained by appealing to the very constituency which the hospital considered its client, i.e., the community. The client itself rejected its role. The basis of the hospital's relationship to the community, its existence as the "storehouse for undesirables," could only

be maintained if kept secret, and people were willing to pay lip service to the ideal; the "good people" in the community left the "dirty work" to the hospital and acted as if they had nothing to do with the hospital's practices. When the discrepancy between the real and the ideal was made public, the politicians and the community in general, in order to maintain their own integrity, had to repudiate and disclaim responsibility for the hospital's practices. They did this by abandoning the very man they themselves had hired to protect them from the patients to begin with, the Superintendent, and placed the burden of blame on his shoulders.

In the mental health field, as in most others, the hypocrisy between the real and the ideal was publicly deplored only after the discrepancy was publicized and could not be denied, and it was safe to do so. In the case of our hospital, once the governor appointed the Task Force to investigate conditions, which was in direct response to public pressure, which in turn resulted from the newspaper series describing the deplorable conditions and political power struggles within the state, the Superintendent resigned, and a number of professional staff who had previously supported the administration came out in open rebellion against it. In short, these reactions confirmed our belief that most people knew about hospital conditions, but chose to ignore them. This impression was further validated by the fact that most of the new changes that took place were taken directly from a list of grievances and questionable hospital practices we had submitted, and a number of high level administrators left.

2. Professional Responsibility

The techniques of confrontation, to expose the sham-like quality of many of our

Therapy and diagnostic testing have no more of a role in an environment of squalor and dehumanization than Shakespeare's works have a place in a community of starving Biafrans.

mental health practices, when used by the mental health professional may have an "unprofessional" ring. The ideal claims that it should not have to come to this, that professionals are rational and humane, etc. But the reality is that mental health professionals are no more rational or humane than any other group. In regard to our own profession, it may be possible to understand how psychologists have rationalized inaction in regard to the ghetto, the war, etc., but we cannot understand how any self-respecting psychologist can fail to support social action when it pertains to the plight of patients. We believe it is unethical to do so—it conflicts with our professional code of ethics. Thus, we see the role of the psychologist who works within a traditional state hospital as being that of a catalyst which brings to the fore the inequities of the social system, and presents proposals and methods for meaningful social change. Therapy and diagnostic testing have no more of a role in an environment of squalor and dehumanization than Shakespeare's works have a place in a community of starving Biafrans. It is clear to us that professionals are as frightened to speak out as any other group in our society, threatened as they would be by loss of prestige, money and advancement possibilities. It is equally true, however, that the professional, due to his facility with language and his ability to immerse himself in technical matters, can rationalize his inaction better than any other group. In recognition of professional fears and eval-

sions, we suggest that the code of ethics of all professional groups contain a section which spells out the professionals' responsibilities in regard to taking action when he is faced with situations in which people's legal or civil rights are being violated.

This code would require professionals to do more than click their tongue at injustice, or simply pass the buck to their superiors. It would spell out specific steps that the professional must follow when he believes inequities are taking place. In a hospital, for example, a procedure similar to filing a union grievance might be used. The administration would then be required to respond to the grievance. However, the mental health professional's responsibility remains to explore and present to the administration solutions to the problems. If satisfaction is still not achieved on a local level, the problem ought to be brought to the attention of his local organization whose responsibility it would then be to evaluate the situation. If the grievances were found to be valid, the professional organization should be required to bring pressure to bear. It is our opinion that when bureaucrats and administrators realize that professionals will not play the game of "cover up," the game will no longer be played. We suggest that the term "loyalty" be redefined from loyalty to an institution to loyalty to clients; and loyalty to clients in an institutional setting cannot be limited simply to the time we spend with patients in therapy.

Summary

We have talked about the fact that there are ideals toward which every mental health worker agrees to strive when he enters his profession. Similarly, there are political ideals, toward which members of a political structure agree to strive. Yet it

doesn't seem as if many persons are motivated to work toward these ideals, except perhaps specific people like students, Blacks, and other stigmatized and powerless groups. Politics seems to suggest that once a person secures some element of the ideal, the very nature of the attainment changes him into a realist, whatever that means. What we believe it means is that people who have reached this exalted state do not want to give up the comfort they have achieved, the economic security, the power, or whatever.

We are left with a rather naïve question, namely, because this is the way it generally has been, does this mean that it is essential to the human condition to behave in this way? Or isn't there a way to transcend to the real, i.e., need for safety, expediency, and power, and strive toward the ideal? Is it possible to be in a position of power, security and comfort, and still struggle for something you believe in? We have wondered whether the scandals that are emerging in government, the protest to the war, the struggle of the Blacks and our youth are causing all of us to raise these questions, or are these events in fact a reflection of people being more willing to take a closer look at themselves and see the discrepancy between the real and the ideal. Do the current scandals, in fact, reflect a growing self consciousness and a willingness to confront

and alter the hypocritical and destructive aspects of reality?

As we look back, we realize that our confrontations with the reality of the establishment have served to clarify for us who we are. At times, we felt guilty for not having gone further, for being vulnerable, and we questioned our motives and goals when we felt this way. At other times, however, we were proud of ourselves, proud that we took stands on what we believed in even though we felt in jeopardy. We also realize that each of us could not have done it alone, that we needed help and support from others in and out of the hospital. Similarly, we urge all the mental health professions to look again at their ideals and pool their community resources so that the reality of mental health services can conform more closely to its ideal.

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Elmer M. Straight, M.S.W.
Sara Bell Allen, M.S.
Margaret L. Straight, M.S.W.
Joseph A. Whitener, M.S.W.

Mental Hospital Employees and Social Action

An account of action by a group of hospital-based employees in keeping and improving a community facility is presented. Acting as interested, informed citizens, the workers were able to gain community support.

With the great emphasis placed on community care and treatment, hospital staffs have become more interested in the quality and quantity of community services to which the released mental hospital patient will have to turn.

There are circumstances when interest alone is not sufficient. For instance, when community facilities and services are inferior or are not available, a broader responsibility devolves upon hospital mental health workers. They might participate in the implementation of a community social club for former mental patients or the periodic detail of a mental health team to isolated rural communities. There may even be need for involvement in controversial

social action in effort to bring about the development of some needed community service.

Becoming involved in community social action, however, is fraught with hazards. Most mental health professionals are employed in agencies supported by public funds. Therefore, they are not free agents and are, to a large extent, bound by the goals and structures of their employing agency. For this reason many practitioners have been reluctant to become involved in community problems not ordinarily related to their work.

The hospital worker is frequently faced with the reality that many patients could leave the hospital if certain community services or facilities were available. Ordinarily, the responsibility for development of services would be that of the community leaders or agencies. However, community

The authors are with two large, publicly supported mental hospitals. Requests for reprints may be sent to Mr. Straight at Rte. 1, Box. 152, Coker, Ala. 35452.

leaders may lack knowledge of a specific need or motivation to meet the need even if they are aware of its existence. Community agencies, on the other hand, may be struggling for their very existence against opponents in the community and may be unwilling to assume additional responsibility and/or risks involved in seeking a solution to needs other than their own. Public pressure or skillfully executed intervention from outside sources independent of community funding can sometimes provide perspective for community leaders as well as agencies.

This paper is a description of community centered action taken by ten mental health professionals employed in two large, publicly supported mental hospitals.

Description of Problem

The power struggle between a large, relatively well-staffed, long-established and prestigious agency (which we will call the Community Center) and a number of less-endowed and less prestigious social agencies (particularly one agency, hereafter called the Neighborhood Shelter) had long been an acknowledged fact among persons serving the community in such various capacities as board members, employees, or merely interested citizens. The incident that brought the struggle to the attention of the community involved these two and several other agencies that were hoping to expand their services by seeking additional money from a United Fund Agency with limited resources.

At the request of the local Council of Social Agencies, three persons, whose specialties were in the field of recreation, were sent to the community by a national agency to conduct a survey of the local social and recreational agencies (hereafter called the Survey). Their findings were dis-

tributed by the Council of Social Agencies to the boards of the United Fund and its member agencies in a 207-page report which impressed many people as unduly favoring the Community Center, while being very critical of the Neighborhood Shelter. The principal conclusions of the report were that the Community Center had an outstanding staff and program that were superbly meeting the needs of the middle class but not those of the lower socio-economic population of the community. One of the recommendations of the Survey Team was that the Community Center be allowed to expand facilities and staff. By so doing, they would increase services to the lower socio-economic group.

The Neighborhood Shelter, whose services were already directed to this group, received a criticism. It was stated in the Survey report that the Neighborhood Shelter was not adequately meeting the needs of any segment of the community's population and should conduct a self study to show evidence that it was effectively meeting any community needs. The report stated, "The plan and the promise of the ability to deliver an expanded future program should come before funds are secured . . . without some kind of plan-ful justification for its existence, it would be difficult to recommend its continuation for very long." Although other agencies received some criticism, none were challenged in this manner.

The obvious threat to the very existence of the Neighborhood Shelter prompted its executive director and some of the board members to seek support from interested citizens both through personal contact and the news media. For several weeks the newspaper carried various articles regarding the findings of the Survey. During that time, two board members independently approached two different hospital-based social

workers seeking some kind of help in the defense of their agency. These social workers in turn talked to other persons both within and outside their hospitals.

Decision to Become Involved

Among the 25 hospital people who discussed this situation, the majority favored doing "something" but did not immediately agree upon what would be appropriate. The consensus was that the Community Center was "good" but was not, by any stretch of the imagination, a competent supplier of services to all segments of the population, nor could it realistically be expected to meet all of the community's social and recreational needs. On the other hand, even though most of the hospital people involved in this discussion had no vested interest in the Neighborhood Shelter they were concerned with what appeared to be in their opinion the "onesidedness" of the Survey. The concern was not so much for this particular agency as it was about the pattern the attack on the agency had taken. It was a well-known fact, to insiders, that some community leaders had certain agencies they favored and supported (financially and emotionally) over all others. Some powerful leaders occasionally sought to perpetuate "their agencies" at the expense of other community funded agencies.

At the time our group was starting to take shape, none of us had facts with which to deny or support the accuracy of the report, but most agreed that there was cause to question its objectivity. The group was convinced that something should be done by someone! Most of the discussants were willing and eager to help but it was felt advisable to limit the activity to 10 people (to be called "committee") to avoid immobility and unwieldiness.

Some Risks of Involvement

Committee members (whose average length of experience since receiving their degrees was ten years) were aware of the consequences of ill-conceived, inadequately planned action. One of the first issues of concern was the possible consequences to the committee members, as individuals, in relation to their employers, if they became involved in controversial social action. The results of any action could be contrary to the wishes of some community leader who opposed or favored one or the other of the agencies involved. This possibility was forestalled by discussing the community problem with the hospitals' administrators and declaring the intention of the committee to intervene in some manner.

Although the committee members were given permission to use some time during the regular work hours, it was agreed that the identity would be as a citizens group and not in the name of the hospitals. This condition allowed the committee freedom to act spontaneously and decisively with minimal fear of pressure from community leaders through the hospitals' administrators. Likewise, this arrangement protected the hospitals from criticism. In the event that controversy resulted from committee action, those committee members using regular work hours would be recorded as having been on annual leave.

Background of the Problem

In considering the risks, the committee had to be aware of the structure and composition of the power group who control policy making for the social and recreational agencies of the community. This group is best described as small but somewhat split. Several of the more outspoken leaders are first or second generation resi-

dents of the community and wealthy businessmen who are heavy contributors to and avid supporters of the Community Center. They either could not or did not want to consider the need for any other organization to provide social and recreational services. Another segment of local leadership is composed of adult brothers, sisters, sons and daughters of the powerful aristocracy. Some of these people are board members of the United Fund Agency as well as of one or both of the agencies under discussion. A third segment is composed of highly-positioned officials in federal or state institutions or large local businesses, or in large nationally dispersed industrial plants. In general, the Community Center has the corner on the market of the most influential persons in the community. Most of the Neighborhood Shelter's board members have less community-wide influence, although a few of the most powerful persons are willing to hold board membership in both agencies.

With this knowledge, the committee anticipated that communications of plans, progress and recommendations made to leaders who had multiple agency affiliations would be passed on to other leaders with whom the committee had no established communication. From there, the information would pass on to other people in the community.

Course of Action

After identifying and recognizing the risks involved, the committee, as an initial step, drew up a resolution which was released to the local press. In this resolution, the committee identified itself as a professionally trained (social workers) citizens group, questioned the objectivity of the Survey regarding the Neighborhood Shelter, and expressed the opinion that a large and important segment of the community

needed services (such as those which the Shelter purported to provide). The services of the committee membership were volunteered for the purpose of providing a thorough evaluation of the situation presented by the Survey.

During the early strategy planning meetings the committee considered alternative action that could be taken. Several of these alternatives were: 1. point out, item by item, what appeared to be questionable validity, reliability and erroneous implications drawn from facts stated by the Survey; 2. make a separate survey of the adequacy of county social and recreation agencies; 3. stir up public sentiment in support of the Shelter by testimonials to be obtained from members and their families regarding the benefit they received from the agency; 4. offer professional consultation to the Neighborhood Shelter's executive director and through him to his board on more effective public interpretation of the purposes and functions of the agency or; 5. make an objective, systematic evaluation of the Neighborhood Shelter.

After considerable discussion, the committee agreed that its most effective contribution to the community would be to present a comprehensive, accurate collection of pertinent, objectively collected data regarding the Shelter's program. A major problem at that point was that the committee had only two weeks before the United Fund budget hearing in which to make the study and present its positive or negative findings in written form. At that time the United Fund Board would make the decision to either continue or discontinue funding the Neighborhood Shelter. It was decided that the method most appropriate for the rapid gathering of the kind of information needed was a combination of three approaches: analysis of agency records; semi-structured interviews with the

agency's membership and staff; and systematic observation of the activity program. The limited time required that each participant work rapidly and intensely but with care not to distort his particular area of observation.

To coordinate and guide individual endeavors, the committee formulated a set of purposes and a procedural outline covering general and specific areas of inquiry. The purposes of the study were:

1. To describe the social and economic background of the members served by the Neighborhood Shelter.
2. To describe the types and quality of the agency's program.
3. To assess the benefits derived from the agency program by the members.
4. To identify the explicit as well as implicit goals of the agency.
5. To determine the extent to which the existing facilities and staff were meeting the agency's goals.
6. To offer constructive criticism of the program and to suggest ways in which the program could be strengthened and expanded.

The procedure involved a detailed analysis of the agency's "hard data" which included attendance records, activity records, membership cards (which were in essence a questionnaire providing a wealth of social and demographic material), expenditure records and minutes of the board meetings. The agency's program and the interaction patterns between staff, and between staff and members, were assessed by six observers. In order to avoid disruption of the usual activity program, there were never more than two observers in the agency's activity area at one time. Arrangements were made with the executive director for the observers to visit the agency unannounced during the two week period of the

field observations. Each observer had specific, as well general, observational and interview assignments. The procedure allowed observers to drift around the agency, participate in activities when appropriate, and talk with members and staff when possible. Notes were made after leaving the agency. A total of 21 observational hours were spent in the agency. Many more hours were spent by committee members sifting, tabulating, analyzing and interpreting the data.

Findings

The study yielded evidence that indicated: 1. that the Neighborhood Shelter was providing to a segment of the community services that no other agency was as well located or geared to provide, but that the quality of service needed improvement; 2. that the agency's facilities were in use to full capacity; 3. that there were insufficient staff to develop the program to its full potential; and, 4. there were several areas of severe weakness involving the administrator and his functioning.

Although the committee believed, at the outset, that two weeks would be too little time for the group to make a comprehensive appraisal of the situation, this turned out not to be the case. In fact, the length of time was an important positive factor in enabling the committee participants to maintain momentum to gather necessary information and to provide a report while community interest was high.

Community Leaders Listen to Citizens Groups

When the committee first became involved in this activity, several members wondered whether anyone would be interested in or be guided by any statements made by the group. This question had

some merit, since an organized group of mental health professionals had never before openly expressed an opinion regarding this community's social problems and, also, the committee numbered so few.

The committee found that a large segment of the community was interested in hearing what a group of professional citizens had to report. The actual number of the committee's membership was not as important as the "image" the committee projected and the fact that the report did not attempt to make generalized statements without adequate substantiating data. Additionally, the report did not, by implication, either defend or condemn any individual or agency. The factors that counted were the clarity of the committee's position, the factual information obtained and the effectiveness of the group's spokesmen. The extent of interest aroused was evidenced by the fact that throughout the study various committee members received interested inquiries from many sources about the progress of the evaluation. The final report received front page newspaper coverage and time on local radio and television newscasts. The committee also learned that although plans had been made based on the findings of the Survey, to withdraw community financial support from the Neighborhood Shelter, these were cancelled after the committee's public questioning of the Survey.

After the report of the committee's study was made public, several community leaders made public their opinions that the study was timely, objective, informative and helpful both to the Neighborhood Shelter and the United Fund in considering the agency's immediate and future financial needs. The committee members have been told that their help may be requested soon with another problem.

Conclusions

It is the belief of the participants that hospital-based mental health professionals have a responsibility beyond the gates of their places of employment. They can contribute significantly to community problem solving by making their skills and expertise available. In some cases, this can be done within the function of one's agency; in others, it has to be done in the role of an interested citizen.

In the social action of this committee, social science methods were coupled with the tools with which mental health practitioners are most skilled and comfortable—interviewing, observation and diagnosis. Also employed was the understanding of community organization which was essential in the planning, executing and reporting of an intervention that averted the needless loss of an important service to the community.

Charles Baron, M.D.

Starting a Mental Health Association

The author defines the steps to be taken in establishing a local mental health association. He stresses the need for advance planning to meet the desires of the community and describes the purposes for which the MHA exists.

It has been aptly stated¹ "The nature of a community health operation is determined entirely by the community in which it is operating. Whatever the kind of community mental health operation that you are trying to develop, it will take its character not so much from you as from the community which it is attempting to serve."

My community encompasses three counties containing approximately 250,000 inhabitants in Northern Kentucky. It is directly across the Ohio River from the city of Cincinnati, Ohio. Fifteen years ago a nucleus of dedicated citizens met with me to resolve to meet the mental health needs of our area. In any program of this nature there are two necessary steps.

First, by contacting those groups and persons whose work or profession contains considerable interpersonal relations, we found that the needs were formidable. Many did not know or recognize that they had these needs. In a survey by direct conversation, questionnaires, letters and telephone calls, fresh ideas were introduced.

Those individuals and groups who were contacted were: social agencies who needed psychiatric and psychological referral service; judges of circuit, county and juvenile courts who needed medical and not solely punitive measures in dealing with many lawbreakers; the clergy, who most heartily cooperated in this survey to describe their needs in pastoral counseling; and physicians, who expressed a need for inexpensive and easily available psychiatric and psychological referral sources. Other groups included the police, who expressed the desire to understand and recognize the mentally ill in their varied contacts and parent-teacher associations which needed an entire

Dr. Baron is a past president of the Kentucky Mental Health Association. His address is 209 West 34th Street, Covington, Ky. 41015. This article is adapted from a paper delivered at the 7th International Congress on Mental Health held in London, England in August 1968.

program on mental health. The three newspapers in our community became allies in our development. They accepted editorials by this author and were the means for making known our first public meetings. The associations for the mentally retarded welcomed our surveys and approach for evaluations, reorganization and reorientation of parents. This was also true for the cerebral palsy group.

This entire assessment may take months, even a year or two, depending upon the population, needs and organization of the fact-finding group. If a dedicated and knowledgeable leader is not available, financing may be necessary to procure a professional worker.

Secondly, with these needs determined and measured in terms of possible resources, a public meeting should be called to which everyone is invited from whom the survey material was obtained. Included in the public invitation are all citizens who have any interest in the subject of mental health in the community. The material is presented and discussed. Then an ad hoc committee is formed. The work of the ad hoc committee will require knowledgeable people, leaders in their community, particularly representatives of those groups whose needs were expressed in the original survey. This committee will study the material and discussion that preceded its formation. Their study will result in recommendations at the next public meeting for a formulation of resolutions of the needs of the community, purposes of an association and the formation of a mental health association. Following this presentation and discussion of the recommendations, action should be taken to form a board of an association for mental health. This elected board will make plans to write the articles of incorporation which would state clearly

the needs of the community and the purposes of the mental health association to meet these needs. That portion of the articles of incorporation of the Northern Kentucky Mental Health Association stating the purposes and specific objectives is as follows.

The purposes for which said corporation is formed are:

1. To promote general community activities bearing upon the opportunity of the individual to achieve satisfactory social and personal adjustment, and specific facilities for the treatment of the mentally ill.
2. To study and to evaluate mental health resources in this area and its needs.
3. To provide services for the prevention, discovery, diagnosis and treatment of mental and emotional disorders.
4. To promote mental health among all people in this area.
5. To plan and to sponsor conferences, seminars, and workshops for professional, educational and other groups.
6. To integrate, coordinate and to supplement existing mental health facilities.
7. To foster the establishment of a mental health clinic.
8. To provide counseling and guidance services.
9. To cooperate in the training of psychiatric personnel.
10. To study bills and existing laws pertinent to mental health and their administration.
11. To enlist members and volunteer workers to raise funds and to employ personnel to carry out all the objectives here and above mentioned.
12. To cooperate with other organizations and agencies promoting the purposes herein above set forth.

13. To do any and all other things reasonably necessary to effectuate the purposes herein above set forth.

The structure of the Northern Kentucky Mental Health Association stems from the membership of the association. At its annual meeting, one third of the board of 21 is replaced or renominated as the nominating committee suggests. The terms are for three years. The officers of the corporation consist of a president, one or more vice-presidents, secretary, treasurer and such assistants or other officers as the Board of Trustees will determine. The standing committees are as follows: Publicity; Liaison to Kentucky Association for Mental Health; Membership; and Legislation and Education. The Education Sub-Committees are: Family Life Study; Pastoral Program; Neighborhood Program; Police Education; and PTA and School Liaison Teenage Program. A program director and secretary staff the association's headquarters.

Services are divided into three areas. 1. Education—community mental health programs (talks, plays, films); developing resource library; special public education programs; professional education activities. 2. Information—about local mental health facilities and referral; mental health literature and program aids. 3. Coordination—with other local agencies in order to strengthen the health and welfare services for people of this area and to minimize duplication of efforts.

Our telephone line is hooked up with the Comprehensive Care Center three blocks away so that unavoidable absence from the association office can be covered.

At this point, special reference must be made to our membership in the Associated Health Agencies of Greater Cincinnati (AHA), a part of the Greater Cincinnati

Community Chest. The AHA consists of the following agencies: Council on Alcoholism; Diabetes Association of The Cincinnati Area; Greater Cincinnati Council for Epilepsy; Hamilton County Council for Retarded Children; Mental Health Association of The Cincinnati Area; Northern Kentucky Mental Health Association and the Social Health Association. Each agency has two representatives on the board of the AHA. The AHA as a united and associated group speaks and acts in a collective manner for the agencies in relationship to the Community Chest for funds, outlines collective goals and programs, helps the individual agencies with their respective budgets, and shares personnel and materials in the activities of the individual agencies. Personnel for the individual agencies are sought by the AHA and with the cooperation of the agencies are hired after being interrogated as to qualifications. This has worked out well for the Northern Kentucky Mental Health Association because of an interchange of needs. Goals are mutually defined. This strengthens our ability to implement these goals through the Community Chest.

The AHA has defined the job description for a program director which is applicable to all the agencies.

The specifics of the program director's responsibilities, insofar as the NKMHA is concerned, are as follows:

1. Act as consultant to chairmen of standing committees.
2. To be responsible to meet needs for films, materials, and pamphlets for the work of the Association.
3. Keep a record of various community groups and their program chairmen—best time in April after election.
4. To be present at all board meetings.
5. To submit to the board the chief

activities and meetings in which he has participated during month—present to board monthly.

6. To keep books incidental to upkeep of the association and to transmit bills to A.H.A.

7. To keep record of dues and membership lists.

8. To gather reports at end of year from each standing chairman and publish combined reports for all association members.

9. Check with secretary that all members of association receive proper material throughout year (first of year—dates of all meetings; copies of new Constitution and By-Laws to all board members).

10. To keep a copy of all clippings of association (scrapbook).

Through the years, volunteers have been activated to do occupational therapy in the neuro-psychiatric departments of the hospitals, raise funds to award scholarships for training in the mental health field and assist in mental health programs such as plays, discussions, seminars and depth study days. Some volunteers have become proficient speakers and discussion leaders, creating a valuable speakers bureau. Throughout fifteen years of activity, the amount of public education has been considerable. One of the highlights has been an annual day of study, from ten in the morning until late afternoon, which draws approximately 200 citizens, not only professional and involved people, but students from the two

local colleges and student nurses from the training schools. This demands the best speakers and teachers we can find. Much time is allowed for discussion and for distribution of literature pertaining to the subject. In addition, a newsletter is sent out to all members of the association, containing local, state, national and international news items which present a total picture of the problems and progress in mental health.

From all this, one important result has become obvious. There is a growing change in the climate towards mental illness in our community. Mental health has become a desirable goal. An active educational program meeting many requests is imperative, necessitating a full time program director. We were able to convince the state of Kentucky that we needed treatment centers. The state Department of Mental Health sent us our first professional worker. Based on the formation of a treatment center, we were able to become part of the Community Chest, relieving us of the necessity of our own separate fund raising drive. We became part of the yearly United Appeal Fund for Service Agencies. And at last, we now have two Comprehensive Mental Health-Mental Retardation Centers, which are supported by local, state and national funds.

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Foster Mothers and Mental Patients

An exploratory study of interpersonal relationships

With foster care for mental patients becoming more popular, it is necessary to discuss appropriate expectations for this care. Should it be a rehabilitative resource or a custodial one? The author studied the types of foster mothers used in one program and postulated that the authoritarian foster mothers, who were in the majority, were suitable to a model of custodial care. Foster mothers with a mixture of authoritarian and humanitarian ideologies, or a humanitarian ideology, are appropriate for rehabilitative work.

Overview

Foster care for the mentally ill can be traced to Gheel, Belgium. Beginning in the seventh century, many mentally deranged individuals made pilgrimages to Gheel, seeking the curative powers of Saint Dymphna. The outgrowth of that tradition was the evolution of supervised community living arrangements for mental patients. Today in Gheel, non-institutionalized mental patients comprise 10 percent of the population of 20,000; they are reported

to enjoy a remarkable degree of participation in the life of the community.¹

Foster care programs have shown a slow and uneven development in the United States. Although a program of foster care for mental patients was introduced by Massachusetts in 1885, in the ensuing seven decades only 22 other states had followed this lead.² By 1963 the total number of mental patients in foster care had grown to 10,397,³ representing about 2 percent of the patients under care in 262 public hospitals.⁴

The foster care program developed by the Veterans Administration started comparatively later and developed faster. The federal program was instituted in 1951 and by

Dr. Smitson is an associate professor and director of psychiatric social work, Dept. of Psychiatry, U. of Cincinnati, Cincinnati, Ohio 45229.

1964 there were 7,200 mental patients in foster care homes,⁵ representing 13 percent of the total number of psychiatric patients under the care of Veterans Hospitals.

There is reason to predict that in the future, family care will be more extensively used as a resource for mental patients. The current movement in the mental health field is away from institutional care and toward more community-centered programs. Indeed, this current emphasis on extra-mural programs of care for the mentally ill has been given impetus by experience with foster care programs. From whatever source, there currently exists a widespread conviction that the mental institution should be restricted to transient, episodic use for care of mental patients.

Although it seems safe to predict an expansion of foster care programs for mental patients, the character of future programs is difficult to anticipate. Unfortunately, programs appear to have developed more as an expression of dissatisfaction with institutional treatment than as a coherently elaborated conception of treatment. It would appear that the future course of foster care for the mentally ill will be shaped, to some extent, by experience and research which may provide further clarification about the characteristics and therapeutic potentialities of the program.

Review of the Literature

A review of the literature documents the scarcity of suitable foster homes. Some attention has been given to the reasons for the hospitals' failure to recruit caretaker facilities more actively. The lack of development of foster care facilities has been attributed to resistance on the part of both the general public and hospital administrations.⁶

While no reports could be found that explicitly described the process of fostering mentally ill adults, a few articles offered suggestions about certain aspects of the foster parent-patient relationship. One report suggested that the process of foster care could be examined within the framework of a parent-child relationship. The author stated that mature people who have experienced satisfying parental roles with their own children are most desirable as caretakers. However, the limited evidence available suggests that this model of mature parenting may not be realized in the individuals actually providing foster care.⁸

Expectations of Foster Care

One uncertainty about foster care for mental patients concerns the expectations appropriate for this type of program. The Joint Commission on Mental Illness and Health maintained that family care for mental patients "is an effective rehabilitative resource."⁹ On the other hand, Irving noted that "family care is generally used as an extended custodial resource—not as a rehabilitation resource."¹⁰ Magner, in a questionnaire study of 70 psychiatric hospitals, found two types of family care programs. One group of hospitals viewed their family care programs as rehabilitative resources, while the other group saw the programs as non-rehabilitative, or custodial.¹¹ These divergent expectations may reflect experience with programs which differ in their missions for the care of the mentally ill. This situation may also reflect different conceptions of rehabilitation itself. Nevertheless, if some foster care programs are to be active vehicles for treatment, a host of questions about how a therapeutic foster care environment can be achieved must be answered.

The Method of This Study

A sample of 40 experienced foster mothers drawn from the Veterans Administration Hospital community placement program, in Bedford, Massachusetts, was studied. The data were collected during an extensive semi-structured interview conducted in the foster home. Data were obtained relevant to the subjects' relationship characteristics, which made possible the identification of relationship patterns presumed to be reflective of the quality of relationship each woman formed with patients under her care. The three levels of relationship characteristics, identified from literature prior to the study, are:

A. Predominantly Authoritarian Ideology Toward Relationships

1. Perception of other people as givers or takers.
2. Marked difficulty differentiating between significant others.
3. Marked difficulty differentiating between significant others and self.
4. Tendency to describe people in such global terms that the description could apply to many people.
5. Little or no perception of the internal needs of others.
6. Evidence of ego attitudes, of clinging to Position to the Other).
7. Significant others are handled by an ultimatum concerning abrupt termination of the interpersonal relationship.
8. Tendency to describe the entire interpersonal process only in terms of activities, favors, or similar impersonal events.
9. Tendency to describe others only in terms of external behavior rather than internal characteristics (feelings).
10. Giving and withholding of favors as a way of managing significant others.
11. Expectation of repayment or concrete show of gratitude followed by disappointment and anger if gratitude or repayment is not forthcoming.
12. Low tolerance for independency in significant others.
13. Strong tendency to attribute maternal qualities to males.
14. Unusual importance placed on controlling people in terms of the magical process of identifying and labeling others (for example, people are labelled as good or bad, givers or withholders, sane or insane and related to accordingly).
15. Unusual need for omnipotence.

B. Unstable Ideology Toward Relationships (Mixture of Authoritarian and Humanitarian Ideologies With Identity Shifting From One Polar Position To The Other)

1. Sex of the object is of great importance.
 2. Unusual curiosity about the personal lives of others.
 3. Tendency to develop triangle type relationships in an effort to continue reaching a solution to the oedipal conflict.
 4. Tendency to choose love objects like themselves since they have failed to achieve complete sexual identity.
 5. Expression of doubt about adequacy in the role of parent and/or spouse due to an inadequate identity.
 6. Tendency to demonstrate exhibitionistic attitudes.
 7. Strong bids for admiration.
 8. Beginning signs of the development of reciprocity in relationship functioning.
 9. Evidence of a sexual conflict being converted into a symptom.
 10. Evidence of anxiety around the oedipal conflict.
 11. Relationships characterized by jealousy.
 12. Relationships characterized by rivalry.
- #### *C. Predominantly Humanitarian Ideology Toward Relationships*

1. Evidence that dependency has been resolved.
2. No wish to exploit others for one's own satisfaction.
3. Comfortable in "giving" of oneself.
4. A readiness to respond to the expressed or unexpressed needs of another human being.
5. Respect for others in terms of seeing them as they are.
6. Awareness of the unique individuality of others.
7. A concern that the other person should grow and unfold as he is.
8. Transfer of libido from the parental figures to contemporaries, community groups, teachers, leaders.
9. Knowledge of others in terms of some perception of their inner feelings (perceiving independence of others).
10. Libidinal cathexis transferred to objects of the opposite sex.
11. Investment at this level is not primarily a relationship to a specific person; rather it is an attitude, an orientation, which generally relates to all people.
12. Courage in relying on one's own powers in the attainment of goals.
13. Evidence of sublimated interests.
14. Evidence of impersonal ideals.
15. Ability to tolerate and expose one's own shortcomings.

Data pertaining to the above characteristics, along with observations of the foster home environment, were analyzed to

achieve differentiations of subjects on the basis of the dominant levels of relationship performances with patients.

In brief, global impressions derived from all of the interview data, observations of each foster home environment, and the specification of diagnostic indicators from the raw data served to classify each subject on the three-point relationship scale.

Findings

The model foster mother in this group was beyond middle age and had an eighth grade education. She had worked as a foster parent for less than 5 years and was providing foster care to a group of 3 to 5 patients. These subjects are generally comparable with previously described groups of foster mothers. Parks found foster mothers to have an age range of 47 years, with a mean of 48.7 years.⁸ Eighty-six percent of his study group were currently married and the subjects had education achievements ranging from the sixth grade to business school. Fanshel,¹² reporting on foster mothers for children, noted that 29 percent were over the age of 50 and that 4 out of every 10 foster families studied had been in service with the agency for less than 3 years. In addition, 27 percent of the group studied by Fanshel had completed 9 to 11 years of schooling and 34 percent had completed 0 to 8 years.

One of the most important issues of this research was whether the foster mothers under study, by use of the diagnostic indicators and observations, could be located on the three-point relationship scale adopted for the research. It was found that the level of relationship functioning was in most instances readily identifiable from the data; all subjects under study were classifiable by relationship level. The relationship capabilities of foster mothers are presented in Table 1.

Authoritarian ideology toward relationship functioning was predominant in this sample of foster mothers. The distribution in Table 1 would rarely be obtained from a random sample of people equally located on all three ideology levels ($X^2 = 8.50$, $p < .02$).

The difference between the climates that seemed to characterize the homes of foster mothers having authoritarian, unstable and humanitarian ideologies was conspicuous and pervasive, touching every aspect of relationship functioning between the caretaker and the foster patients in the home.

The data revealed that a foster patient in a home of an authoritarian oriented foster mother would perceive a caretaker who demanded conformity, afforded little or no recognition to his individual needs, and projected an absence of warmth and sensitivity in relationship functioning. A patient living in a home with a foster

TABLE 1
*Distribution of Foster Mothers by
Rated Levels of Relationship
Functioning*

Levels of Relationship Functioning	Number and Percentage of Subjects	
	Number	Per- centage
Authoritarian Ideology	25	62.5
Unstable Ideology	9	22.5
Humanitarian Ideology	6	15.0
	40	100.0

mother possessing an unstable ideology, would be likely to experience a somewhat intrusive and sexualized but sensitive interest in him as an adult. He would find a sustained opportunity for meaningful relationship engagement from a woman who had limited capacity to appreciate his capacities and limitations. A patient living

in a home with a caretaker having a humanitarian orientation would be likely to experience a very sensitive, warm interest in him as an adult. He would find opportunities based on his own needs for relationship engagement from a woman who considered him as a fellow human being, capable of the whole range of emotions and feelings.

Discussion

The differences in the foster homes studied clarify a controversy in the literature over the appropriate expectations of foster care. It will be recalled that foster care has been seen alternately as either a custodial or treatment resource. The homes studied in this research suggest that both views may be appropriately held. Homes of the authoritarian foster mothers seem best able to offer a boarding room service, while homes of mothers having unstable identities in their orientations to others appear to have the capacity to extend more progressive social experiences to patients. This would suggest that the difference in views currently advanced may well be an expression of experience with homes which differ in capacity to provide a constructive social environment.

In light of this study, it seems appropriate to conceive of distinct services for different levels of fostering and to devise appropriate supporting services to aid in the achievement of these services. A supportive program (such as occupational therapy in the home) could be adjusted to the relationship potentialities of foster mothers, enabling them to function more effectively within the limits of their capabilities.

The demonstration of such sharp differences in the quality of fostering would justify a shift from our present focus on how many patients are in foster care to a concern with what kind of foster care is being offered. This change in focus creates,

in turn, the opportunity for staff time to move from a dominant concern with placement of patients to the selection of parents. Indeed, the number of patients in placement may be an inappropriate index of the success of a foster care program.

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Lindbergh S. Sata, M.D.

David A. Perry, M.A.

Carol E. Cameron, M.D.

Store-front Churches in the Inner City

The authors describe a preliminary survey of twenty-one store-front churches in Baltimore's inner city. They examine the role of the churches and their ministers in helping recently arrived migrants adapt to urban living. This source of community strength may be valuable to the mental health worker.

Urban renewal and condemnation proceedings continue to change the superficial appearance of the inner city, but the human problems remain and are heightened. The establishment of a Community Mental Health program within an urban area must be cognizant of these dynamic changes and accommodate for shifting populations and their resultant problems.

Baltimore's Inner City Community Mental Health program was initiated in January, 1967. Treatment components include a variety of community based activities, in addition to traditional, federally mandated services. The program is responsible for 95,000 residents who are from the lower socio-economic strata of the city. Approximately 48 percent of the population are Black Americans representing migrations from the Deep South during the past two

decades. The remainder of the population is composed mainly of ethnically derived white sub-cultures and pockets of recent white migrants from southern states. Available demographic data demonstrate the entire spectrum of social and physical deprivation and include high rates of physical and mental disability, unemployment, illegitimacy, crime, economic dependency, etc.

Early in the development of the community mental health program, it was clear that the social and psychological needs of the potential consumer were inseparable. The enormity of developing comprehensive total-care services as an objective of a community mental health program required the examination and full utilization of all potential community resources. In this context, storefront churches, root doctors, food kitchens, were each considered as potential contact points with citizens within the community.

Lacking relevant information on storefront church operations, a tentative plan

Dr. Sata is Associate Medical Director at Harborview Medical Center, 325 9th Avenue, Seattle, Wash. 98104. Mr. Perry and Miss Cameron are medical students at the University of Maryland School of Medicine.

was established to survey and develop a dialogue with ministers of store-front churches. This would permit opportunities to convey goals of the mental health program, as well as develop some understanding of the role of the store-front churches within the inner city.

Description

Three predominantly Black populated census tracts with the greatest density of churches were chosen for this survey. Although the investigators were only able to locate store-front churches with characteristic names or with window paraphernalia, there were approximately 65 churches of all descriptions in this area. Those churches belonging to known demoninations and housed in conventional structures were eliminated from the first study. The remaining 45 churches were crudely converted stores or row houses. While some of these store-front churches had fairly elaborate stonework and windows painted to resemble stained glass, there were some with only crudely painted signs indicating the name of the church and the hours of worship. Chapels ranged from living-rooms in row houses to large commercial buildings. Services were conducted in the evenings and on weekends. The churches were functionally inoperative during the week-day.

Many of the ministers lived in stable areas of the city with intact neighborhoods of higher socio-economic status as compared to inner city ghettos.

Twenty-five of these churches were personally contacted by a team of two investigators, resulting in twenty-one ministers interviewed. The remaining twenty churches

were unoccupied when visited repeatedly and no initial contact was made. It is recognized that those churches not included may be of a markedly different character than that revealed by the present study. A large-scale survey currently in process will help in clarifying this issue, but is beyond the scope of this paper.

Procedure

White visitors to Black congregations were viewed with either suspicion or subservience. Such responses created unnecessary barriers in conveying community mental health information, or initiating a dialogue to understand the role of store-front churches in the community. For this reason, ministers were contacted outside the context of religious services in several ways. Prior to the evening service, ministers were contacted on the premises or by telephone to arrange for interviews in the minister's home. To facilitate discussion and dispel concerns over issues of territoriality, it was explained to them that the investigators desired to talk to representative community leaders to gain knowledge of the needs of the community, as seen by the ministers, as well as providing information on mental health services being developed in the inner city. No demands were made for volunteer community service or a commitment of the minister's time. A written description of the Community Mental Health Project was provided at the time of the initial interview.

Findings

It had been assumed that most of the ministers lived in the general vicinity of their churches; however, the majority proved to live away from the immediate neighborhood. Only a few had their

church located in their homes, on the first floor of a two- or three-story row house. Many of the ministers lived in stable areas of the city with intact neighborhoods of higher socio-economic status as compared to inner city ghettos. The congregations represented a mixture of individuals living in the immediate church vicinity and those who traveled from other areas of the city.

Store-front churches are functionally transitional and impermanent and are affected by a variety of forces present within the inner city. The existence and location of a church vary with the movements of the minister and his needs for convenience, as well as with condemnation proceedings for urban renewal. Contrasting with this trend for evanescent inner city store-front churches was at least one example of a store-front development of forty years' duration occupying a permanent location in a large inner city commercial building.

Nineteen of the twenty-five ministers interviewed were Negro males ranging from the mid-thirties to 81 years of age. The six remaining ministers were Negro females over the age of 40. Traditional certification for clerical training was uniformly lacking and legitimization of the ministerial role was varied. Some expressed a response to a divine call to work in a church. Others received an informal apprenticeship under the direction of a ministerial colleague in a different store-front operation.

At least one minister systematically studied the Bible in a quasi-academic institution. One of the women interviewed was a member of a conventional orthodox church and practiced avocationally on weekday evenings. She stated she had been called to serve in that particular location.

Although it was originally assumed that store-front churches were independent and isolated operations, the vast majority had

affiliations on a regional, national, or international basis. These included the Mutual Baptist Convention, Jehovah's Witnesses, and Bible Way Worldwide. Annual meetings of these associations were held in various cities, including Miami Beach and Tokyo. Some of these organizations were divided regionally, into districts, circuits, or divisions. A few churches were affiliated with a religious following limited to the southeastern United States. Only one or two churches admitted to total independence.

In the presence of a hostile, unconcerned environment, store-front churches comfort and counteract the impersonal aspects of urban living.

The notion that store-front churches exploited inner city residents could not be substantiated. By and large, collections were minimal and ministers were not motivated by monetary gain. The majority of ministers worked regularly in daytime employment and avocationally for the churches as evidenced by the preponderance of evening services. Although half of the ministers lived in more desirable neighborhoods, their homes were modest and in keeping with incomes derived from daytime employment. Most female ministers were married to men of higher socio-economic status and lived more comfortably than did their congregational members. Of the twenty-five ministers contacted, only one individual seemed to lack altruistic motives and was idiosyncratic in his response to the interview. He was flamboyantly dressed at church while his home was shabby. He lacked any interest in the mental health program and showed no concern for congregational problems.

In those instances when church financing could be appropriately discussed, it was learned that the expense of renting the building was often beyond the means of the congregation and the minister was required to use his secular income. Some subsidy was possible through parent organizations, but such help was minimal.

Ministers varied considerably in personality, background, orientation, and in their respective belief systems. One minister indicated she took all problems, including those of diabetes and alcoholism, to "Doctor Jesus". Others indicated their daytime affiliation as volunteers in outpatient facilities of mental institutions.

With the one exception cited earlier, all ministers interviewed seemed interested and concerned over the state of their neighborhood and their congregation. Their willingness to meet with staff members and to exchange ideas gives promise for future cooperation.

Several of the ministers exhibited qualities best described as charismatic, but the majority of the ministers were soft-spoken, gentle individuals without striking personality characteristics. Their level of sophistication regarding emotional illness reflected in part their socio-cultural and religious backgrounds. Most were able to recognize alcoholism, unwanted children and "craziness", as being directly related to the need for developing treatment services. On the other hand, etiological belief systems ranged from demoniacal possession, to brain injury, to interpersonal problems as the basis for mental illness. Some of the ministers frankly admitted ignorance in this area.

Discussion

Store-front churches represent an interesting phenomenon in urban settings. Lacking acceptance by established religious systems,

they function in the shadow of old, established churches. The established churches continue to serve congregations who have long since left the area and who return to worship only during service hours. In this context, the store-front churches tend to attract ghetto residents and are more closely related to the immediate neighborhoods in which the churches reside. Despite non-acceptance by the established churches, their continued existence as biblical literalists tends to support the thesis that store-front churches fulfill a need for many of the ghetto residents.

Store-front churches must be viewed from the perspective of ghetto residents rather than compared to other religious institutions reflecting middle-class value systems. The store-front churches in Baltimore appear to represent a cultural and religious integration of value systems cherished by congregational members. In ecological terms, the ghetto residents represent the more recent migrations from the southern states looking for improvement and opportunities in basic living. Whatever may have been their past, the inner city has provided little escape or constructive redirection of the feelings of oppression. In the presence of a hostile, unconcerned environment, store-front churches comfort and counteract the impersonal aspects of urban living. The limited membership, the use of widely known hymns without the requirement of reading and the opportunity to share communally provide ghetto residents with a culturally adaptive mechanism for coping with the urban dilemma.

Etiological belief systems ranged from demoniacal possession, to brain injury, to interpersonal problems as the basis for mental illness.

Hagnell,³ in studying Swedish populations, and Odegaard⁴ in studying Norwegian migrants, have demonstrated the relationship of migration with increased psychological morbidity. It seems reasonable that rural to urban migrations require greater adaptive capacity as compared with rural to rural, or urban to urban, migrations. Black Americans are further compromised by cultural exclusion as discussed by Brody,¹ and subject to the socio-cultural economic inequities of a large minority group. Under such circumstances it is understandable that religion would be the singular unifying force for these Black Americans. The concentration of store-front churches in the inner city provides less orthodox but more meaningful religious worship for recently arrived migrants. Claude Brown's²

world in *Manchild in the Promised Land* would seem to indicate its time-limited function and the difficulty of appreciating such religious practices once cultural ties with southern communities have been lost. Nevertheless, a bridge for assimilation into the larger culture of the city is provided and is adaptive in this regard.

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As I Lie in Bed

*My daughter plays the piano
Music rising and falling
Like
Sand dunes swelling
And sinking.
And here I lie
With your hair rising
Close to my eyes
Like black grass
And your ear-
Light washed shell.
Oh, Sunday morning
And empty sea shores
Of my mind.*

—Annie Wu

Walk-in Exposure Projects in the Ghetto

Racial and class stereotypes are largely caused and reinforced by lack of contact. The author describes a school project in which students were required to go into unfamiliar environments and get to know the people. In cases where genuine efforts were made to become involved, students reported definite attitude changes.

The stereotyping between the white middle class and the Black ghetto is mutual. An obvious way to break down this double barrier is to promote direct person-to-person contact, without agency role or social function, between the ordinary Black ghetto residents and the ordinary white middle class residents.

This is precisely what we tried, and succeeded in accomplishing, in two projects. The first project was a course "Exercise in Trust and Sincerity in Unfamiliar Environments" which I ran at the Experimental College of San Francisco State College for three semesters from 1966 to 1967. The second project, which began in 1968 and is still in operation, is a field experience assignment as a part of the course "Minority Groups" which I teach at California State College at Hayward. This article will discuss these two projects and their implications.

Dr. Maruyama is an associate professor of sociology at California State College at Hayward, 25800 Hilary Street, Hayward, Calif. 94542.

First Project: Exercise in Trust and Sincerity in Unfamiliar Environment

The focus of this project was not limited to Black ghettos, but included other "unfamiliar environments". The class enrollment was 16, 18 and 14, respectively, in the three semesters. Altogether 8 students went into Black ghettos. In addition to the Black ghettos, the locations of projects ranged from a wealthy business executives' bar to San Quentin prison.

At the beginning of the course in each semester the students received this outline:

The student chooses an environment in which people tend to relate to outsiders with mistrust or polite formality while concealing their true feelings. Examples of such environments are: ghetto, homosexual bars, prison inmates, ethnic groups. Excluded are environments which welcome outsiders such as Synanon. The student enters the environment as an individual without institutional position, organizational function or agency label, and works out a personal rapport with those who live in the environment.

The student learns (1) to think in the logics and ethics of those who live in the environment; (2) to be accepted on the level of true feelings and acts; (3) to relate on person-to-person basis across social and cultural differences; (4) to discover himself as a person, not as a position or function.

When requested by the people in the environment, the student may participate or assist in activities initiated by them. But the student should not consider himself or act as a do-gooder, a reformer or a patronizer. His attitude should be that of a learner of an unfamiliar culture and an apprentice in personality enrichment.

The student spends approximately five hours a week or more in an environment of his choice. A weekly seminar is held to exchange experiences.

The students' experiences varied in their nature and mode as well as in their degree of success. For our present purposes, let us focus on those students who went into Black ghettos, and discuss the successes and failures among them.

One of the successful was Maureen, a conservative, attractive blond girl who went into Hunters Point by herself. Hunters Point is considered to be the worst Black ghetto in San Francisco. Maureen wore jeans and went to the playground "on the Hill" (in the middle of Hunters Point). Teen-age Black men were playing baseball. She stood and watched. The ball came rolling to where she was. She picked it up and threw it to one of the men. He said: "Hey, you can throw a ball," and she was accepted into the baseball game. After the game was over a man, about 20 years old, who was in the game, invited her to his family. It turned out that the family had about ten children and was at the dinner table. She had a dinner with them. She was invited to the family several times. Later she went to a large dance party on the "Hill" with her girl friend, and they became ac-

quainted with some Black people at the party.

She summarized her experience in the following words: *"The work I have done for this course in the Hunters Point area has enlarged my identity beyond that of a nurse and has enabled me to extend myself in a more sincere way. I have discovered myself to have a greater capacity for empathy and honesty, which in brief has made me more effective in my work. The hostility that we feel upon entering a foreign or threatening environment is only the fear and prejudices which exist in the self. After four years of college, my education was really a limited thing."*

Nicholas accomplished two projects in one semester. First, he went to downtown San Francisco, found an old vagrant and stayed with him for two or three weeks, practically 24 hours a day except when attending classes. Nicholas slept with him on fire escapes, begged passersby for dimes, and learned his way of living and philosophy. His second experience was with a Black man who had just come out of a prison. Nicholas met him on the street. The man was looking for a job. Nicholas was living in an apartment in the periphery of Fillmore. He let the man use his garage to start a car-washing business. The man often stole from Nicholas's apartment but Nicholas stayed on friendly terms with him. Nicholas related with him as an equal, and this was crucial in his successful rapport with the man. The man's business grew steadily. He also got a job at a gas station, from where he could get more clients for his car-washing business. Everything went well until the man had trouble with the police and disappeared.

Not every student was successful. There was, for example, a girl who went to a half-way house for men who had just come out of prisons. She went to the house weekly

to talk with the residents or to play games with them. Several times the residents invited her out to their parties. But she never

"I wondered how I would react if after I went into the Black community I found that I really was not the liberal, open-minded person I considered myself."

went. The class discussed this many times. Her reasoning was that she could not fully trust the "ex-convicts" and she felt that they might force her to take narcotics or offend her sexually. Many in the class, who knew "ex-convicts," felt that her fear was overrated. The class suggested to her that if she had developed a sincere relationship with the residents she had nothing to fear.

She still could not bring herself to be more sincere with the house residents. She finally dropped her project.

Another girl failed in a similar way. She went to the American Indian Center often and talked with Indians who happened to be there, never becoming personally involved. She asked them about Indian cultures and told them about her (Chinese) culture. On several occasions she was invited to Indian families. But she always found excuses for not going, or agreed to go but did not show up. This was discussed in the class. Her explanation was that she thought the Indians were inviting her out of politeness without meaning it and without expecting her to show up. Finally she realized that she wanted to avoid personal involvement. The class discussed this several times, but she never accepted the Indians' invitations.

Second project: Field Experience as a Part of a "Minority Groups" Course

The focus of this course is mainly the Black ghetto, though the ghetto areas of

other ethnic groups are also included. The course is a one-quarter course. The enrollment is completely renewed each quarter. Enrollment averages about 60. The majority of the students are from suburban white middle class, with no or very little contact with the Black population. About 80 percent of the students are girls.

The course outline, given at the beginning of each quarter, includes the following:

Each student is required to do a field experience of his own choice and planning. The purpose of the field experience is to expose yourself to a new situation and to develop or revise your feelings and attitudes. This is not a "research" project to observe people or to conduct interviews, but is a search into your own mind under a new experience. You go into an environment as an individual, not as a role or function. You get to know people on a person-to-person basis and learn their points of view, feelings and philosophy.

Examples of locations are: West Oakland, Fillmore, Hunters Point, North Richmond, Mission District in San Francisco, Union City, China Town. It is important that you do not go through any agency or organization, but directly step into streets and meet ordinary people, not selected or pre-arranged people. You may go to bars, pool halls, bowling alleys, parks, recreation halls, food stands, laundromats, barber shops, beauty shops etc. You may go alone, or you may go with your boyfriend or girlfriend.

Non-Black students are expected to go into a Black community. Black students may go to a non-Black minority community or to a conservative white community.

Each student is required to either write a term paper on his field experience or to make an oral presentation of the field experience in the class. The term paper is to be about 10 pages in length, and to consist of three parts: one or two pages on your feelings and opinions (also fears, if any), before the project; several pages of what happened in your field experience and what went on in your mind; and one or two pages on your feelings and opinions after the field experience.

Here again in this project, there are successful students and unsuccessful students. Let us discuss some cases of both successful and unsuccessful experiences.

One of the successful was Annette:

I faced the prospect of going into a Black neighborhood with mixed feelings. My first

reaction when I discovered that this was an assignment project was that perhaps I had registered for the wrong class. I had expected to read and discuss about the minority problem. This field work was an entirely different approach. I had very little experience with or knowledge of the people in Black community. I am white, middle class, and had attended private schools for twelve years.

Although I considered myself a "liberal," I had never put myself to the test. Supporting open-housing ordinances, condemning George Wallace, or voting for candidates whom I thought offered constructive solutions to the Black-white problem—all things I had done in the past—did not require much courage or real examination of my attitudes. Going into a ghetto was something entirely different. I was not sure I was prepared to do this. I wondered how I would react if after I went into the Black community I found that I really was not the liberal, open-minded person I considered myself to be.

There was another aspect to this fear. I was not entirely convinced that it was safe to walk, even with an escort, in the streets of West Oakland. The mass media continually reported the frequent incidents of crime in ghetto areas. My parents and friends were aghast at the thought of my going into West Oakland. Convincing a friend to accompany me was also difficult. But as I tried to convince him that it was perfectly safe, I half-convinced myself.

Our first attempt was a failure. We started in the area of Ninth Street and Broadway, hardly the heart of the ghetto area. My reasoning was that I should start there to gain a little confidence, and proceed into the Black community. Several Black women were standing at a corner, apparently waiting for a bus. We approached them and asked about a bus. One woman answered and then began speaking about the weather, the Bay Area Rapid Transit System and other topics, but before we were able to talk about anything else, the bus came and she left. None of the other people in the area seemed to want to talk. I sensed indiffer-

mixed. I was disappointed. I spent a good deal of time trying to understand what went wrong. Was it my attitude? My clothes? My approach? Did I convey an attitude of insincerity or condescension? Did I behave like a social worker? Then I began thinking that perhaps the people I had come into contact with simply did not want to talk. Perhaps they were not convinced that I was interested in what they had to say. My rather undefined feelings toward Black people had not changed or been developed at this point.

My second trip into West Oakland was more successful. On a Saturday afternoon we went to the area near Housewives Market on Ninth and Jefferson. Again this was not exactly the heart of the ghetto. I had the same excuses as before. After speaking to several people we finally approached a Black woman who was waiting to be served. After speaking with her for a while she offered to show us what she called "her place" if we really wanted to go. It did not seem as though she really expected us to go. We assured her several times that we were interested in talking with her and the people she knew, and that we were not connected with the police.

On the way, our conversation ranged from a discussion of the Oakland Police Department and their harassment and lack of understanding to food prices in the ghetto stores. We discussed the administration of welfare money, Eldridge Cleaver, unemployment and resentment of the Black community toward the failure of the war on poverty. We walked down streets with small, run-down pool halls, bars and shops. Mrs. Williams continued to speak of the city administration's lack of concern for the people in the ghetto. She was especially bitter about the Acorn Urban Renewal Project which had forced many residents out of the area. The plans called for massive improved, low-cost housing, yet only token attempts in this direction had been made.

As we walked along we noticed many people just sitting or standing on the streets. Apparently they had nothing else to do. After what

"I had this ridiculous idea of being bitten by a rat"

ence rather than hostility. We wandered around the area for some time, speaking to a few people without developing any real conversation.

My feelings after this initial failure were

seemed like hours of walking, which in reality was less than an hour, we reached her home. It was small, old but well-kept. I was apprehensive about going in. I had this ridiculous idea of being bitten by a rat. The inside of the

house was neat, simple and crowded with children. On the wall there was a large picture of Malcolm X and on the other a picture of John Kennedy. I began to feel more at ease. We continued our conversation. We were thanking her and were about ready to leave when her son came in with several of his friends. He seemed stunned to see us there and the atmosphere became a little tense. As it became evident later, he was active in Black Panther movement. He spoke to his mother for a while. Then he suggested that we sit down and "rap" (speak) with him. It seemed more of a command than an invitation, so we decided to stay. The conversation was often loud and profane but it was an exciting experience. He not only told us about his own background—how much time he spent in detention centers etc.—but also about his association with the Panthers. He told us not only of their political activities but also of their attempts to instill a feeling of Black pride into Black youngsters, and of their hot breakfast program. This had not been my concept of what the Panther organization was like.

This young Black revolutionary also forced me to examine my attitudes and really to search into my mind. He demanded to know where I stood, whether I was going to help them in their struggle or I was going to be part of the "honky establishment that was going to be burned." Where did I stand? I had not been forced to decide prior to that time. I told him that I sympathized with his goals but that I could not give a blanket endorsement of the use of violence. I did not believe that all other possibilities had yet been exhausted. He was obviously not pleased with my answer but he did concede that if that was my position I, as a part of the white community, should provide meaningful alternatives to destruction immediately. We then moved onto a discussion of *Soul on Ice* and *Malcolm X*.

Eventually we had to leave. It was early evening by then and I was not looking forward to the long walk back downtown. As we passed, the people still standing on the streets did not seem hostile or frightening any more—simply curious. We were out of place. Yet only few made any remarks about the fact.

Many of the initial fears were gone. Simply by being in the area I had clarified my feelings to a degree. This meeting was the high point of the field experience. It was the first time I had really talked with any Black people and the first time that I had to find out what my feelings really were. Thirdly, on this trip I felt that I learned something which made our subsequent visits more enjoyable and rewarding.

"What I was afraid of was that perhaps I wouldn't be able to find any Black people that would like me."

We returned to the area several times and spoke to many different types of people: housewives, ministers, hustlers, school dropouts, children. We did not always speak of "issues." Usually it was rather unimportant conversation. However, we got to know them better. In the process we often received first-hand information about larger concerns and problems. For example, one young man we spoke to was awaiting a trial on arson charges. While he had been living at Parks Job Corps Center he was accused of setting fires in several rooms. His description of his later encounter with the police and the court system made it clear to us that equal treatment under the law is more myth than reality to Black people, especially to poor Black people. There is a double standard; laws and procedures for the rich and those for the poor. The injustices of the bail system alone are outrageous.

As a result of the field experience my feelings and attitudes toward Black people have become more defined and clearer to me. I had sympathized with the "problems" of the Black community as I saw them, but I really did not have any firsthand experience or knowledge of them. Through this experience many of the fears and attitudes I had about Black people are gone. The term Black Panther no longer frightens me, for example. Becoming able to speak with people on a person-to-person basis rather than a white person—Black person basis has made me more secure. I found that I could dislike individual Black people as I do individual white people without feeling as though I was a racist or a bigot. I no longer feel compelled to like all Black people. I am now able to react to them on a personal, individual human level rather than as a group.

This field experience has also left me with a sense of anger or guilt and unease that I did not have before. As a member of the white community I feel responsible for the conditions that the Black people face. I am a part of the "Establishment" simply because I am white. I am part of the group that has the power to make changes. This is a realization that I did not have before."

Another of the successful was Marilyn:

"Upon first hearing of the assignment, I was very reluctant about going out and confronting a person of another race and background on an individual basis. After some introspection, I began to realize some interesting things about my feelings and prejudices. I realized that I would not have been as hesitant about speaking to someone if I were not required to go into their neighborhood and confront them "on their own ground." The idea would have been much more appealing to me if I were at college, for example, or in an environment familiar to me.

As I thought about my feelings more, I began to discover that much of my hesitancy was based on fear. I was actually afraid of what might happen to me if I went into a ghetto area. I began recalling rumors and stories I had heard as far back as I can remember; stories of white people being attacked with knives or beaten, or women being attacked by Black men. Although my rational sense told me that these stories were largely untrue, I still was afraid.

After much mental preparation, one Saturday morning I went into West Oakland. I thought that the best place for me to go was a grocery store. I knew I couldn't help but look somewhat conspicuous. But I tried as much as possible to look like I was really shopping.

My first attempts failed, but finally I got up enough courage to approach another Black lady. She seemed friendly, and I began talking to her in a rather light conversation concerning which brand of canned vegetables is best, since we were standing in front of the canned foods

"They knew that once I became a part of the 'establishment,' I would lose my interest in changing things, or even if I didn't, they knew very well that I as an individual could not do very much."

section. She seemed willing to talk, and the conversation went well as we began to talk about food prices and other topics related to home-making. Suddenly it occurred to both of us that we were standing in the middle of the shopping aisle, talking at some length. After formally introducing ourselves (Her name was Ruth), she suggested that I come with her, as she was going to meet her husband in a nearby restaurant. I gladly agreed and was relieved by her friendliness.

When we walked into the coffee shop, her husband looked quite surprised to see me with her. But Ruth acted rather matter-of-fact when she introduced me to him (Joe). We sat down to have a cup of coffee and I found that after the initial strangeness of my being there had worn off, he too was talkative and friendly.

Ruth told Joe that I attended Cal-State, and all of us began to talk about general things: weather, school, and the like. I asked him if he had lived in California for very long. He said that he had moved here about twenty years ago from Georgia. He left Georgia after the Depression in the hope of finding better opportunities in California.

When he had talked about his past, he began asking me more questions about myself. Neither of them was as surprised at my confession that I was doing it for a class as I had thought they would be. When they asked why I was really taking the class, I said I needed to earn units in sociology and I wanted to learn something about people so we can work together. I want to have a sociology minor in order to become a social worker. For the first time during our entire conversation, which had already lasted a couple of hours, I felt them both stiffen up and there followed a very definite, chilling pause. I did not know what to say, until it occurred to me that maybe it would be again best to be honest, and asked them why they had such a reaction to the mention of social work.

At first they tried to cover up and said that there was nothing at all wrong with it, and that a lot of young college graduates were interested in going into that type of work. But I told them that I had noticed a very definite negative response, and that I was really interested in finding out what the people on the other side felt about social work.

Joe talked as if all he knew about social work was through his friends' experience. His main complaint was that social workers always made the recipients feel ashamed for needing any assistance. He said that it was quite a demeaning experience to have a worker check up on a recipient at any time of the day or night, paying a surprise visit, expecting to be welcomed with open arms, and giving the impression of trying to catch the recipient doing something wrong which would be cheating the middle class tax payers. He said that social workers somehow have the idea that anyone who is receiving financial help automatically needs other help in the form of counseling or advice. He said that social workers pass on to the middle class public the attitude that anyone who wishes to work can do so, and therefore anyone on public assistance is lazy and should either be taught not to be lazy or be punished by being made to feel

defeated. After another pause, Ruth interjected an idea of her own: She knew that many workers have very good intentions, but they expect a person to make a decision like the one they would make themselves because their thinking is influenced by their own background. Then she paused.

I had not thought of social work in this light. I told them that they had made me think about things in a whole new way. I asked them if there was anything I could do as a social worker to make things any better. But neither of them looked very hopeful. They knew that once I became a part of the "establishment", I would lose my interest in changing things, or even if I didn't, they knew very well that I as an individual could not do very much.

Another student, Ann, directly experienced the interaction between a ghetto family and a social worker and the police department.

"Until my high school days I was a member of the migrant worker group. I saw many Black people in the fields. But I was taught not to associate with these 'dirty people.' I can remember when I was seven or eight, I thought Black people were black because they did not take baths.

Of course, as with all children, I didn't obey my parents and usually played with the Black kids. I can remember being ashamed because I couldn't have my friends come to our tent. But I always seemed welcome in their shacks. There was also a different feeling in the Black kids' home than in mine. In their home there seemed, looking back, a spontaneous love which didn't need to be expressed in words.

I have never been frightened by Black people, but I am now. I am afraid to put myself in a position where I am the outsider. Yet when I was a child I was the outsider in Sally's family. But I didn't realize it then. It is too bad one loses his childish trust.

One Sunday I went to Seventh Street in Oakland and stopped in a coffee shop. I really didn't expect to have much luck finding someone to talk with. There was a lady with a young boy sitting at the counter so I sat next to the boy. I started talking to Jimmy and soon his mother was also talking. I told her who I was and why I was there. She obviously thought it was a funny idea. But she didn't laugh. Our conversation was confined to the antics of children and the coincidence that our children were approximately the same age. Mandy has two sons: Bill, age sixteen; and Jimmy, age ten. She also had a daughter Joyce, age thirteen.

After I had known her for a while Mandy told me that she is very much afraid her children will not escape the life she has had. Mandy is a widow. Her husband was killed in a fight while in prison in Georgia.

"The social worker says Joyce should not get used to going to dances and 'things' because this is not the kind of life she will live when she grows up."

Mandy has not worked since Jimmy was born. She wants very much to stay home with her children. She has existed on welfare for almost ten years. She seems to be naturally a very open person, but it is obvious that she has learned to say what others want to hear. For instance the first few times I visited her apartment she said things like "all people should try to understand each other", but that was not the way she acted. This is a rather difficult thing for me to explain. I am not sure how I knew she did not believe this but I did. Later she was very blunt in admitting she didn't care what whites thought of her.

I was in her apartment one afternoon when her social worker called on her. I think I made the social worker very uncomfortable. She kept talking to me about "her Mandy" as if Mandy were an object and her property, and as if Mandy were not in the room. I just kept talking to the woman through Mandy. I didn't know at the time if this would hurt Mandy's welfare payments. I was concerned but was too mad to stop. The next week Mandy said Jimmy got an extra pair of shoes. Mandy thought maybe the social worker thought I was some kind of inspector or "something." She really got a kick out of the whole situation.

One night, soon after I had been to a party at her house, Mandy called me at 4:30 in the morning. Bill had been picked up by the police the previous afternoon. She found out this from one of Bill's friends. The police did not notify her. She went to the police station. But she couldn't find out where Bill was or what he had done. She stayed there until 4:30 when she called me. My husband and I went to the station where she met us. We tried to find out about Bill. But we didn't have any more luck than Mandy, although I think we were probably treated with more respect than she was. By this time it was 6:30 a.m. My husband finally called a lawyer friend of ours. Our friend came about 8:30 a.m., and within thirty minutes Bill was leaving with his mother.

"It is so simple for a white person to get out of this type of situation"

It is so simple for a white middle class person to get out of this type of situation. What concerns me is that Bill, sixteen years old, was picked up as a robbery suspect. He was not booked, merely picked up on suspicion. Yet his name is on the record for this. Our lawyer friend says this record should not exist and yet thousands of people have this sort of "record." The law also says this information shall not be given to the public, yet it is very easy for credit agencies etc. to obtain this information. This happens quite often to Black people.

Is it any wonder Black people are filled with hate? I am amazed this hate has not manifested itself sooner and with more violence than it has.

This social worker really concerns me. From what Mandy says the social worker has absolutely no concept of Black people's beliefs, needs or desires. For instance Mandy has asked for extra money to buy Joyce a dress for a school dance. The social worker says Joyce should not get used to going to dances and "things" because this is not the kind of life she will live when she grows up. I wonder if this woman was ever a teenager. I have only seen her once but I don't think she is over forty. Surely she can remember her teen years. But perhaps she had little fun as a teenager. She is unmarried. Mandy also told me that the woman tried to get Mandy and her children to join a Black Baptist church.

This experience is going to take a great deal of time to evaluate. I am rather slow at sorting out my own feelings. I don't think my feelings about the Black man have basically changed. The only feeling I have is one of utter frustration. I don't know how to solve the white person's problem, and it is a white problem, not black. I think I feel good about being accepted by Mandy and her children. But I hope I don't feel smug about this. I think they accept me only because I didn't try to help. That is I didn't try to impose my standards on them.

I thought I would easily disentangle myself from Mandy and her family. But instead I find I enjoy their company. I have no intention of cutting myself off from some beautiful people; there are too few around."

Failures

The students' performance in field experience was rated as A, B, C, D, Incomplete and W depending on the degree of their success. The criteria were:

A: went into a ghetto area, became acquainted with one or more persons on the street, in a laundromat, a bar, a pool hall, etc., engaged in frank and sincere conversation, and gained insights in depth.

B: went into a ghetto area, became acquainted with one or more persons on the street, in a laundromat, a bar, a pool hall etc., but the conversation was either general or limited to "safe" topics without frankness and depth in feelings, beliefs and philosophies.

C: went into a ghetto area but failed to get into a substantial conversation, or went into a semi-ghetto area.

D: went into a ghetto or a semi-ghetto area, but obtained no insight. Inc: has not written up the field experience as of March 15, 1969.

W: withdrew from the class before the end of the quarter.

The tabulation for the first four quarters showed 54% with A's, 31% with B's and the rest below B.

The Type B failure was mainly due to the student's fear of or shyness in touching upon specific personal experiences or feelings. In most of these cases the student felt inhibited in bringing up a topic, but rationalized his inhibition as politeness. The results of the students who obtained Type A success indicate that in no cases was there a refusal on the part of the ghetto residents to discuss the topics which the A students brought up but the B students did not. Therefore the "politeness" of these B students was unnecessary and unjustified. The Type B failure included a small number of cases in which the student was invited to some places but did not go.

The Type C failure was mainly due to the student's fear of non-existent hostility or rejection. For example, a male student decided that he would be attacked in the ghetto, and confined himself to talking with Black persons in the main street area of Downtown Oakland.

The Type D failure occurred when the student went into the ghetto area with patronizing perception, and returned with "benevolent" observation such as considering the ghetto residents as culturally "deprived" or lacking in motivation.

Discussion

In the two projects we learned that:

1. If the student communicates his desire to learn the Black point of view, not to sell his own ideas or to argue, then almost any person in the ghetto accepts the student.

2. The student must frankly express his purpose in coming into the ghetto. If his purpose is to earn academic units, then he must say so when asked. Otherwise the ghetto resident will remain distrustful.

3. Most ghetto residents, when willing, will take several hours of their time in talking with the student even during the initial contact.

4. No student has been physically or verbally attacked.

The last point, however, does not imply that there are no dangerous situations. One student, a professional wrestler, has deliberately created a dangerous situation as an experiment. He dressed up as a pimp with diamond rings, a fancy coat and fancy shoes, and went into Fillmore with a girl from the class who posed as a prostitute. The situation he created was that an unknown semi-colored (he was a Filipino) pimp with an unknown attractive white prostitute was invading the established territory of Black pimps and their prostitutes.

A girl alone, if she wants to conduct a field experience in the ghetto, can always go to a laundromat, a market place or a bus stop to meet some ghetto residents.

She stood at a corner of Fillmore street while he hung around. As expected, Black pimps attempted to take her under their wings, and to pressure him out of the area. The students escaped when three pimps started surrounding him.

On certain streets, standing without a seeming purpose, especially late at night, a lone girl can be perceived as a prostitute. A lone white man in a Black bar may be suspected as a police spy. I recommended to the students that a boy-girl pair arouses less suspicion and can go to almost any place even late in the evening. However, any white person late at night in a ghetto "residential" area, such as some blocks in West Oakland, is obviously out of place. But during the daytime there is no street in San Francisco or Oakland where a white male or a white boy-girl couple cannot walk. If the ghetto residents appear to be suspicious about the white's presence, it suffices for him to initiate a conversation with someone. A girl alone, if she wants to conduct a field experience in the ghetto, can always go to a laundromat, a market place or a bus stop to meet some ghetto residents.

Finally, these considerations apply also to persons who are neither Black nor white who want to get to know Black ghetto residents. The following example by a Chicano (Mexican-American) student serves to illustrate and summarize many of the points that have been discussed:

I have lived my entire life as a resident of this Bay Area community. My ethnic background is Mexican-American (Mexican who has American citizenship). I am a member of the third generation to be born in this country. My parents, and their parents, were migrant workers.

During my lifetime my family has not had to endure any great lasting financial hardship. We have become firmly entrenched in the middle class. I never had to work in the fields as my parents did. I never lived in the "barrio" as they did. I have always lived in a white neighborhood, gone to predominantly white schools, and received a white education.

I am both a full-time student and a full-time wage earner, provider and family man. Most of my time is taken up by study. Therefore I chose a rather unorthodox method of approaching this field experience. I decided that I would use my rest periods, lunch time, and whatever other time I had or could make available at work to try and strike up relationships with other workers.

Fred is a young Black militant. He was the hardest to approach, because he was very suspicious of what I wanted from him. At first he was distant and aloof with a characteristic air of Black superiority. When I tried to get in good with him he gave me a bunch of junk answers; things that he figured I wanted to hear. I came right out and told him that I knew he was trying to give me a line of bullshit so I would stop bothering him. When he finally realized that I wanted to know more about what he felt as a person he was able to open up to me and I in turn was able to get across to him how I felt about what he stood for.

I found out that he wasn't interested in destroying this society. What he really wanted was for all of his people to realize that this society they live in was definitely a self-perpetuating racist society. He told me that he wanted the Blacks to realize that they could change this country's treatment of them if they would unify and become conscious of their common Black culture.

After this initial understanding of his position, I told him that I was afraid that what the Black nationalists really wanted was to completely overthrow the system and create a new

one in which they were in the power. He explained to me that this was a fear that had been conditioned in me by the white racist society.

I asked him what I could do to help the Black cause. He told me something that really shocked me at the time. He said that there was nothing I could do. I asked why and he explained that the Blacks had been the victims of too much misguided help by misguided welfare workers and social servants. If I really wanted to do some good I should try to make the Mexican people aware of their Mexican heritage.

I asked him what he felt about me since by this time I had explained what I had first set out to do. To my surprise he himself had changed in his attitude towards me and he said he liked me because I told him that I had done this as a field experience and had myself been changed as a result of it. We both felt that it would have been much worse for both of us if I had not been honest with him about my intentions. We agreed that the primary difficulty between the races was an extreme mistrust brought about simply because we didn't, or couldn't trust each other enough to be honest about our intentions.

I have gotten to know Fred quite well. First I felt quite guilty because I thought that I was using him for my own purposes. I finally came to realize that this was not what was really happening. I had become his friend and he had become mine. I found that for the first time I had a Black friend. This was really a shock. I told him all about my life and the things that I wanted to get out of my life. I found that I could honestly talk to him and tell him what I felt about him as a person. I like him because he had been honest with me. I feel that he likes me for my honesty with him.

I am ready to admit that at first I was afraid of what was going to happen, not so much that I felt I was in any danger. What I was afraid of was that perhaps I wouldn't be able to find any Black people that would like me. What I found out about myself really surprised me. Fred helped me to find myself as well as to know that what is important is what goes on between two individuals. He reaffirmed my conviction that the most important level of relation is at the person-to-person level.

Beatrice M. Rosen, B.S., F.A.P.H.A.

Ben Z. Locke, M.S., F.A.P.H.A.

Irving D. Goldberg, M.P.H., F.A.P.H.A.

Haroutun M. Babigian, M.D.

Identifying Emotional Disturbance in Persons Seen in Industrial Dispensaries

The authors discuss the extent to which nonpsychiatric physicians working in industrial dispensaries detected emotional problems in their patients. They examine the nature and degree of disability resulting from these problems and the resources used by the physicians in their treatment.

Growing professional interest in the role of the general medical physician in the treatment of patients with mental or emotional problems has been demonstrated by increased emphasis on psychiatric training of the general practitioner and in a variety of recent studies on this subject.^{1, 4-8, 11-15, 17-22} Such studies have shown the extent to

which nonpsychiatric physicians in private or group practice in the United States and abroad have detected psychiatric disturbance in their patients.

This report focuses on the extent to which nonpsychiatric physicians, employed in industrial dispensaries, detected emotional problems among employees, the nature and degree of disability resulting from

Mrs. Rosen, Mr. Locke and Mr. Goldberg are associated with the National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Md. 20015. Mrs. Rosen is a statistician in the Register Development and Studies Section, Biometry Branch. Mr. Goldberg is Acting Chief of the Register Development and Studies Section and Chief of the Evaluation Studies Section, Biometry Branch. Mr. Locke is Assistant Chief of the Center of Epidemiologic Studies. Dr. Babigian is Assistant Professor of Psychiatry and Preventive Medicine and Community

Health and Director of the Division of Preventive and Social Psychiatry, University of Rochester School of Medicine and Dentistry.

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Tables reflecting data in this report are available on request from Mrs. Rosen.

these emotional problems, and the resources used by the physician to treat these patients. Two established companies in an industry of a highly technical nature located in Monroe County, New York, agreed to provide data from dispensaries serving five plants and administrative units with an employee population of approximately 20,000. Each dispensary reported data for a one-month period. The periods covered were from mid-November 1965 to mid-February 1966 and September and October 1966. Information reported on each person seen during the study period pertained to his first visit of that month. The procedures for collecting the data varied slightly among the dispensaries to fit the routine procedures of each dispensary.

The study form used to record the data was divided into two parts. First, information on the characteristics of the dispensary population was recorded. This included data on age, sex, marital status, socio-economic characteristics, years employed, presenting problem, medical diagnosis and number of visits during last 12 months. In general, except for identifying information which was recorded by a clerk, this section of the study form was completed by a nurse or a physician at the time of the employee's visit to the dispensary.

If the patient was judged to have an emotional problem at the time of the visit, the physician completed the second portion of the form, dealing with that emotional problem. This section included information on the physician's impression of the patient's "psychiatric" diagnosis, level of impairment, length of time patient was bothered by problem, previous psychiatric care, and type of mental health care provided by the dispensary.

If the patient had recovered from such a disorder and was judged not to have an emotional problem at the time of the visit,

the section dealing with his emotional problem was not completed.

Findings for this report are presented in two parts. First, information on employees diagnosed to have an emotional problem (the first section of the form) is related to the total dispensary population. Secondly, specific information relating only to the patients with emotional problems is discussed (second section of the form).

This analysis focuses on the dispensary population 20 through 64 years of age. Two hundred and seventeen persons under 20 years of age or 65 years and over were excluded from the study due to the difficulty of interpreting the findings of an "employed" population in these age groups. A few patients (.4 of a percent) were stated to have a "mental, psychoneurotic personality" disorder (ICD, 1957) but no data on a current emotional problem at the time of the visit was provided.²⁴ These patients were excluded from the "emotional disorder" group.

Similarly, relative frequencies were also highest for those living in census tracts of high socioeconomic ranking.

In interpreting the findings, it is important to bear in mind that dispensary personnel were not requested to probe for emotional disorders, but rather to carry on their medical practice in the customary manner. No attempt was made to validate diagnoses or data supplied by the dispensaries. Demographic information was well reported for each patient, but information on previous psychiatric care and other aspects relating to their emotional problem was frequently incomplete. Seasonality also may have affected the findings of the study since the reporting period occurred only during the fall and winter months.

Findings

Comparison of Emotional Disorder Cases with the General Clinic Population. Of the 3,165 patients 20 through 64 years of age seen during the reporting period in the co-operating industrial dispensaries, 153 or 4.8 percent were considered by dispensary physicians to have had an emotional, psychiatric, mental or personality disorder and are designated in this paper as the "emotional disorder" group. The proportion of patients who were determined to have an emotional disorder was lowest for the younger patients and increased for each age group, from 2.5 percent for patients 20-29 years of age to 8.1 percent for those 50-64 years of age. This increase may have been due in part to the fact that older patients who were more likely to have been employed for many years were better known to physicians and the fact that files of their past illnesses and visits were well documented and maintained in the dispensary.

Data by sex show a proportion with emotional problems of 5.3 of every 100 men and 4.1 of every 100 women with relatively higher proportions for men than women in all age groups except 20-29 years of age. However, differences between both the over-all and age-specific percents, by sex, were not statistically significant; therefore, additional data by sex are not presented here.

In terms of marital status, the relative frequency of emotional disorders was particularly high among separated and divorced persons (10.3 percent) but low among both the single (4.4 percent) and the married (4.8 percent).

Information was analyzed for two socioeconomic factors—the employee's occupation and his residence in terms of socioeconomic ranking. Within each occupation group, the proportion of patients with emo-

tional disorders was generally high for those of high occupational status—8.2 percent for managers and 5.8 for professionals. Service workers, which generally included protective personnel, elevator operators, porters or other such workers requiring relatively little training, also showed a relatively high proportion with emotional disorder, 6.1 percent, though they represented a relatively small group.

Similarly, relative frequencies were also highest for those living in census tracts of high socioeconomic ranking (6.8 percent compared to 4.1 to 5.0 percent for other socioeconomic areas). This ranking was based on the classification of urban, suburban and rural census tracts in Monroe County into five major groupings using five census variables to develop a composite index for each tract: median value of owned homes; median rental value; percentage of skilled, semi-skilled and unskilled workers; median years of education of adults; and percentages of sound dwelling units.²³

In general, the proportion with emotional disorders was higher for those employed 5 years or longer compared to those employed for a shorter time. This was the case for all occupation groups except salesmen and service workers, but again, few in these occupation groups were represented in this study. The higher proportions for employees with longer duration of service are due in part to the older ages of these employees where the relative frequency of emotional disorder was shown to be higher, and, as stated before, to the fact that employees working for the company for several years were usually better known to the physicians in the dispensary.

Clinicians were asked to indicate which of the following major reasons induced employees to come to the dispensary: accident or injury, physical symptoms, emo-

tional symptoms, preventive measures, to seek advice or counseling, or for other reasons. Among the "emotional disorder" group, 52 percent went to the dispensary for physical reasons, such as accident, physical symptoms and preventive measures, in contrast to 89 percent of the remaining patients, that is, the "nonemotional disorder" group. On the other hand, about 39 percent of the "emotional disorder" group had emotional symptoms (31 percent) or sought advice and counseling (8 percent) compared to 1 percent of the "nonemotional disorder" caseload. Eighty-four percent of all patients who came to the dispensary because of emotional symptoms were included in the "emotional disorder" group. In contrast, the advice seeking patients generally were not judged to have had an emotional problem since only 39 percent were so classified. Proportions of patients with emotional disorders were largest among older patients regardless of presenting problem, but particularly so for those coming to the dispensary for emotional symptoms or to seek advice or counseling.

Physicians were expected to indicate the medical diagnosis for all dispensary patients requesting care, including those with emotional disorders, which were classified according to the International Classification of Diseases.²⁴ Among the somatic conditions reported for the "emotional disorder" group, the most frequently diagnosed ones were the digestive, circulatory, and allergy and endocrine disorders.

As expected and as shown in other studies, "emotional disorder" cases generally had more visits during the previous 12 months than the general patient caseload.¹¹⁻¹³

"Emotional Disorder" Patients. We have provided an overview of the demographic and medical characteristics of "emotional disorder" cases compared with the general caseload of these industrial dispensaries.

The following section deals primarily with the "emotional disorder" group and focuses on the nature and extent of emotional problems in this group.

In addition to providing a general medical diagnosis, physicians were asked, but not required, to assign a broad psychiatric diagnosis to those patients considered to have an emotional, psychiatric, mental or personality problem. While it is recognized that the assignment of specific psychiatric diagnoses is difficult, it is assumed that non-psychiatric physicians can recognize psychiatric disorders and are able to assign such disorders into broad diagnostic groupings. The extent of this capability is the subject of a future phase of this study.

The fact that physicians were not required to assign a psychiatric diagnosis probably accounted for a substantial portion of the 37 percent of cases in which the space for recording the psychiatric diagnosis was left blank. Nevertheless, physicians judged that 7 percent of the cases had psychotic disorders, 32 percent were psychoneurotic, and 17 percent had personality disorders. The percent with personality disorders was appreciably higher for the older than younger patients. In addition, 6 percent were diagnosed with other or unspecified psychiatric disorders. Age, and/or perhaps length of time on the job, may have been factors in assigning a psychiatric diagnosis to a patient since relatively more of the older patients than the younger ones were given specific diagnoses.

In terms of presenting problems, patients diagnosed in this study as psychotic and psychoneurotic were equally likely to come to the dispensary for physical or emotional symptoms (about 35 percent came for each) but few came for accident or injury, for advice or counseling or for preventive measures. In contrast, study patients diagnosed with personality disorders came at approxi-

Also, unlike the psychotics and psychoneurotics, a substantial proportion of persons with personality disorders came because of accidents or injuries or for preventive services.

mately the same relative frequency for each major category of "presenting problem." Also, unlike the psychotics and psychoneurotics, a substantial proportion of persons with personality disorders came because of accidents or injuries or for preventive services.

When physicians were asked how long they believed their patients were bothered by their emotional disorder, they reported that more than half of their patients were bothered for five or more years, regardless of their psychiatric diagnosis.

Doctors were asked to judge the degree of psychiatric impairment of the "emotional disorder" group. Impairment was reported for 88 percent of the cases. Of these, 15 percent were considered severely impaired, 43 percent moderately, and 37 percent mildly impaired, while 5 percent showed no functional impairment. In terms of diagnosis, the impairment was considered severe or moderate for 80 percent of the psychotics, and 85 percent of those with personality disorders, but for only 51 percent of the psychoneurotics. Although differences were small, impairment was more serious for older patients than younger ones and for those with problems of long (5 years or more) rather than short duration.

Physicians were asked to indicate if "emotional disorder" patients had had previous psychiatric care and, if so, what kinds. Such care was reported for 56 percent of the patients. Of these, 15 percent received care in more than one facility. Eighty-six percent had some form of outpatient psychiatric or ancillary service and 25 percent

inpatient psychiatric care; twelve percent had both types. Thirty-five percent with known care had seen a private psychiatrist, but very few had received services in a mental health clinic or family agency. The use of a private psychiatrist rather than a clinic or a social agency is an indication of the broad medical insurance made available to personnel of these companies as well as their high socioeconomic level. For the 44 percent for whom previous psychiatric care was not reported, it was not possible to determine how many had no prior care and how many had care of an unknown type.

As might be expected, patients with psychotic disorders were more likely to have had previous care and in more than one type of facility than those with other psychiatric diagnoses. In addition, almost all the psychotics (nine of the 10 psychotics with known care) had seen a private psychiatrist in contrast to about 40 percent of those with psychoneurosis and 21 percent of those with personality disorders. Further, six out of ten of the psychotics but only a third each of the psychoneurotics and those with personality disorders were reported to have been hospitalized at some previous time. It might be noted that the item on previous care was completed for almost all of the psychotic group compared to slightly more than half of the psychoneurotics and about three-quarters of those with personality disorders, reflecting to some extent the greater likelihood of psychiatric care for the more serious disorders.

Dispensary physicians were asked to indicate if they had ever provided mental health care in terms of supportive therapy, suggestions for environmental changes, and/or the prescription of drugs for the patients they considered to have had emotional disorders. For those for which a response to this question was given, 96 percent had received supportive therapy, 66 percent were

Also suggestive of further study is the relatively high frequency of emotional disorder among those of high socioeconomic status attending the dispensary.

given drugs, but only 12 percent received suggestions for environmental changes. Sixty-five percent of these patients had received more than one type of care at the dispensary, most frequently a combination of supportive and drug therapy. The only exception was among the psychotic group in which supportive therapy was frequently provided without other forms of care.

Discussion

This paper, which is concerned with patients coming to a medical dispensary, represents one of several recent studies by Locke and associates designed to investigate the extent to which persons are seen and identified by nonpsychiatric physicians as having emotional disorders. The proportion of dispensary patients in this study considered to have an emotional problem, 5 per 100 patients, is lower than the 15 percent reported in a study of general medical group practice¹³ and the 9 and 17 percents found in two studies of patients of private practitioners.^{11, 12} Although the experience observed among the study population is not necessarily reflective of the total employed population in these companies, the relatively low frequency of diagnosed emotional disorders may have been attributable to a basically low-risk, stable, and employed population working in well-paid, prestigious establishments. Further, employees in these companies were initially screened through job interviews and physical examinations, thus eliminating some persons

with overt psychiatric problems. Other factors contributing to the low frequency may have been the encouragement by these companies of adequate health care oriented toward prevention and the partial subsidizing of good insurance coverage. In addition, the companies have been supportive of employees with emotional problems and assist such persons in eliminating stressful on-the-job situations even if this means changing jobs. Nevertheless, an employee with such a problem may naturally fear for his job security or promotional opportunities if his condition were known to his employer.

Another finding of interest which has also been substantiated in a variety of psychiatric settings, is the relatively high proportion of separated and divorced persons with emotional disorders.¹⁰ If the findings among the dispensary population reflect the experience of the total employed population of these companies, then it would appear that a secure employment environment does not alter that association.

Also suggestive of further study is the relatively high frequency of emotional disorder among those of high socioeconomic status attending the dispensary. Previous studies reflecting utilization of psychiatric services indicate that persons of lower socioeconomic status generally had significantly higher rates of utilization.^{2, 9}

There are a number of interrelated factors which may account for the study observation of a relatively high frequency of emotional disorders among the high socioeconomic group:

1. Those included in the high socioeconomic group were generally employees of long standing and, hence, their medical histories were more likely to be known to the dispensary.
2. The employees in the high socioeconomic group tend to be more medically sophisticated and more accept-

ing of the companies' expressed liberal attitude towards emotional disorders. 3. Managers and professionals are trained to be cognizant of the influence of emotional disorders on job performance. Thus, they are more closely associated with dispensary medical personnel and have a direct and more personal relationship with the physician. 4. The relatively lower proportions for the nonprofessional worker may reflect to some extent a lack of trust in the dispensary physicians, particularly in terms of discussing emotional problems. This lack of trust could be related to the employees' concerns of job security and advancement as well as their limited medical sophistication.

Therefore, it is difficult to assess the extent to which each of the above factors contribute to the relatively high frequency observed in the upper socioeconomic group. Stresses associated with responsible positions can also contribute to this phenomenon.

As stated earlier, the findings reported in this study reflect the extent to which emotional problems were diagnosed by industrial dispensary physicians who were requested to conduct their practice in the customary manner, and not as a casefinding project. In the second phase of analysis the ability of dispensary physicians to identify patients with emotional disorders will be studied. Patient data from this study will be matched to the Monroe County Psychiatric Case Register.^{8, 16} This matching procedure will identify the group of dispensary patients who received prior or subsequent psychiatric care. Included will be both those considered to have emotional disorders, as well as those who were not considered to have an emotional problem at the time of the study. This phase of the study will also provide a gross index of the proportion of persons judged to have an emotional disorder who did not receive psy-

chiatric care. Subsequent matchings should make it possible to determine whether or not it is more likely to be reported to the psychiatric register if one had been considered by the dispensary physician to have an emotional disorder in contrast to the patient group not so considered.

Two other studies, also centered in Monroe County, New York, will be the focus of similar matching to the Monroe County Psychiatric Case Register. One involves patients of private nonpsychiatric physicians, and the other patients attending general medical clinics operated by general hospitals in Monroe County. All three studies, each involving different but major types of general medical care in the County, will provide an overview of the ability of nonpsychiatric physicians in a variety of settings to identify persons with emotional disorders.

The study finding that only 5 percent of the employees who came to these dispensaries were considered to have an emotional disorder may have several important implications. If a matching comparison of these cases with those in the psychiatric case register indicates that the "emotional disorder" group was underdetected, a need for further training of physicians in the identification of persons with emotional problems might be indicated. On the other hand, if there is little or no indication of underdetection and if the findings for the dispensary group represent those for the total employed population in these companies, one could infer that a stable, well compensated working environment, accompanied by good health care, is conducive to a mentally healthy employee population. Although this hypothesis is generally not questioned, we are not aware of any other studies conducted to actually investigate this hypothesis.

Summary

This study examines the extent to which nonpsychiatric physicians, working in industrial dispensaries operated by companies in a highly technical industry, detected emotional problems in their patients, the nature and degree of disability resulting from these emotional problems, and the resources used by the physician in the treatment of these patients.

Major findings are as follows:

★ Of the 3,165 patients 20 to 64 years of age seen during the reporting period, approximately 5 percent were considered to have an emotional problem at the time of the dispensary visit.

★ Higher proportions of patients with emotional disorders were noted among the older patients compared to younger ones, for those separated and divorced, for those of high socioeconomic status, and for those employed 5 years or longer compared to those employed for shorter periods.

★ Among patients for whom a psychiatric diagnosis was reported, 32 percent were diagnosed as having psychoneurotic disorders; 17 percent, personality disorders; and 7 percent, psychotic disorders.

★ Among those for whom impairment was reported, the degree of impairment was judged to be severe or moderate for 58 percent of the cases, mild for 37 percent, and no functional impairment for 5 percent.

★ Previous psychiatric care was reported for 56 percent of the patients. Of these, 86 percent had some form of outpatient psychiatric or ancillary service and 26 percent inpatient psychiatric care; 12 percent had both types. Among those receiving outpatient care, 35 percent were seen by private psychiatrists while very few were served by mental health clinics.

★ Dispensary physicians reported that at some time they provided supportive ther-

apy to 96 percent of the "emotional disorder" patients for whom this item was reported, drugs to 66 percent, but suggestions for environmental changes to only 12 percent.

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"Networks and Human Settlements: From Man's Movement to his Communications" is the theme of the 1970 Ekistics Month organized by the Athens Center of Ekistics in Athens from June 29 to July 24, 1970. For more information, contact Mr. P. Psomopoulos, Vice-president International Programs, Athens Center of Ekistics, P.O. B. 471, Athens, Greece.

History

Arthur A. Woloshin, M.D.
Everette E. Dennis, M.A.

The Romance and Rodomontade of Comprehensive Community Mental Health

Comparisons between the moral treatment era and the community mental health movement lead to the conclusion that today's efforts may fail because the lessons of history have not been learned.

Throughout the history of the mental health movement, periods of progress in patient care and treatment have been followed by retrenchment and regression. At a time when American psychiatry and the federal government are committed to comprehensive community-oriented mental health programs, a historical review of the literature reveals that the current hopes and slogans are not dissimilar from those which characterized the buoyant expectations of the past.

Many innovations in the care and treatment of the emotionally disabled can be related to the following paradigm: A new concept viewed in historical perspective is imbued with a romanticism¹ leading to indiscriminate implementation and applica-

tion as well as a boastful oversell. The oversell sets the stage for disenchantment since it is impossible to deliver services to the level promised. Thus, the movement is discredited and it falls into disrepute. Inevitably, a new approach, diametrically opposed to the discredited movement, supercedes it.

The current emphasis and generous funding of community mental health programs demand a thoughtful analysis against the backdrop of the psychology of social movements. People tend to carry sloganistic banners rather than concepts. In contrasting the community mental health movement with such antecedents as moral reform, the emergence of the state hospital system and the development of the therapeutic community, several hypotheses seem evident:

1. That problems of great magnitude tend to be viewed simplistically;
2. That simplistic solutions for complex social and psychological problems are promoted through a process of romanticizing the needs of the people to be served, and
3. That when some degree of "success" is achieved, frequently independent of the espoused treatment modality; it tends to be applied universally without proper adaptation and translation.

Dr. Woloshin, former director of the Northwest Subzone of the Illinois Department of Mental Health, is now in private practice. Requests for reprints may be sent to him at 1866 Sheridan Road, Highland Park, Ill. 60035. Mr. Dennis is the assistant director of the Mental Health Mass Communications Program, Kansas State University, Manhattan, Kansas.

MENTAL HYGIENE

A Historical Perspective

Advances in technology, an explosion of the new knowledge and a continuously expanding definition of mental health problems render many historical comparisons difficult. Yet, by keeping this in mind, it is possible to examine some of the similarities of the moral reform and community mental health movements. Both, based on the judgment of professionals, were used to undergird the layman's romantic response to a contemporary crisis; namely, the maintenance, management and treatment of the emotionally ill and mentally disabled. Similarly, both movements were able to engage the support of laymen in order to popularize some sound clinical concepts and thus gain a broad acceptance. In both instances an unusually articulate lay leader, acting out of a sense of optimistic humanitarianism, helped the idea gain currency. Ironically, many professionals who were not among the initial innovators came to accept the idea with the pessimism of last resorts . . . "Nothing else has worked, why not this."

Moral Reform—The Past Is Prologue

It was Pinel in 1795 who first formulated moral treatment into a system "so soundly conceived and dramatically presented that it caught the attention of the public."² By 1811, T. Romeyn Beck, a New York physician, could write convincingly about moral management of the mentally ill, which, he said, "consists of removing patients from their residence to some proper asylum and for this purpose a calm retreat in the country is desired for it is found that continuance at home aggravates the disease as the improper association of ideas cannot be destroyed."² Central to moral management was "human vigilance," which "had to convince the lunatics that the position of the physician and keeper is absolute. It also

depended on "humane attendants who shall act as servants to them (the patients), never threaten but execute, offer no indignities as they have a high sense of honor."²

The Influence of Dorothea Dix

Dorothea Dix marshalled collective public guilt and pity for the "poor unfortunates" and brought humanitarianism and moral indignation to bear on the mental health problems of her day. She not only fought ignorance, apathy and neglect, but also the prevalent myths and folklore. Keepers of the insane in jails, for example, believed that their inmates did not require heat. Like romantics of previous generations, Miss Dix used abhorance of inhumane conditions and the rising tide of emotional indignation as major tools in her crusade. She was able to exploit the general receptivity to the, "There but for the grace of God go I" philosophy, widely held in the nineteenth century. Even so, Miss Dix still had to work against the strong tide of the existing welfare concept which was based on a bare subsistence level for the mentally ill. It was felt, by professionals and laymen alike, that a person with any minimal self-esteem would react to the asylums and almshouses by getting well. Giving too much comfort to lunatics was not acceptable. Making things too easy for the patient would contribute to his crazed condition.

Those who developed and operated the moral treatment retreats and new asylums of the 1820s and 1830s had no intention of treating everyone deemed a "lunatic"; rather they made a distinction between paupers and pay patients, a problem which Miss Dix pointed up in a subsequent crusade for the dependent insane. The pauper-pay distinction in admissions at such early new asylums as Bloomingdale is not without

parallel in the twentieth century. The selectivity of new asylums meant that those who were rejected would be relegated to jails.² In modern community mental health centers many of the persons who are turned away as "inappropriate" later find themselves in state hospitals.

In the community mental health centers restrictive intake policies usually mean exclusion of the severely and profoundly mentally retarded or those presenting with a chronic brain syndrome. Even today, despite an increase in the availability of

. . . if human services are to achieve any social benefit they will require a consistent and high level of expenditure over a long period of time.

mental health services at all levels, one finds great inadequacy in the quality of diagnostic, treatment and preventive services for most persons of low income and/or deprived minority status. In addition, there tend to be no equivalents of mental health resources in areas of high need. Not only is the quantity of available services lower in deprived areas, but the quality as well, due to the unwillingness of many professionals to locate there and the inability of local social agencies to offer equivalent salaries and benefits. The federal legislation which funded the comprehensive community mental health program is little help since it has provisions that actually work against the fullest extension of services to low income areas by mandatory matching fund requirements.

Cult of Curability

One of the romantic notions of the moral reform period was "the cult of curability". Often humanitarian arguments were of secondary importance while advocates of

the "cult" advanced economic arguments for the great monetary boon (i.e. savings) which the new asylums would provide. By placing the lunatics in asylums away from the contaminating influence of criminals or the poor, they would recover and be able to return to useful lives in society, proponents of the "cult" reasoned. These economic arguments are a little unnerving when one listens to testimony before twentieth century legislatures. This *deja vu* phenomenon invites serious questions about the use of economic rationale in the promotion of mental health services. It is difficult to develop meaningful cost-benefit analysis in mental health, yet if a program is touted on an economic basis, this is the way that it will be evaluated.

We have known for many years that if human services are to achieve any social benefit they will require a consistent and high level of expenditure over a long period of time. In the past the march to the funeral pyre for fledgling mental health programs was often preceded by a "feast or famine pageant" usually related to disenchantment with the level of expenditure. The rapid movement of mentally ill persons through the new asylums would, its advocates said, bring long term savings and relieve much of the expense of overcrowded jails and almshouses. By the twentieth century, community mental health proponents were making a similar case in their testimony before the Congress and state legislatures. Once the moral reformers began to get financial support, they felt a need to collect quantitative data to support their programs. An early annual report by the Utica State Hospital illustrated the institution's splendid progress by listing the net weight gain of patients at the beginning and end of the year, thus reenforcing humanitarian goals of patient care (including eating) with hard, albeit fat, data. Almost

as crude a quantitative tool for program evaluation is the "clinical contact" measure used by some community mental health centers in the 1960s. Clinically we should be more concerned with treatment outcomes than the quantity of service rendered. What do we expect to happen to a patient after he has passed through the various treatment services organized at great expense for his benefit? Many clinicians have yet to suggest any meaningful answer.

As a number of studies of psychiatric history indicate, the moral reform movement had much merit. Even today, many of its basic precepts of patient care are valid. And in addition to exciting therapeutic developments, moral reform struck out against overt brutality and the quieter cruelty of shackles and chains. Unfortunately, there was no effective triage treatment system and the asylums were inundated by overwhelming case-loads from an increasingly populated America, where the tide of immigration was being felt. The system was eventually flooded with too many patients and much of moral treatment was doomed to failure. Its universal application to many patients who did require restraint and other forms of custodial management increased the chances of failure with the result that many of the valid aspects of moral reform inevitably fell into disrepute. Some writers indicate that moral treatment was designed by professionals of the early nineteenth century for persons like themselves. They had not expected the flood of hungry, poverty-stricken immigrants, who came from a different culture and spoke a foreign language. This shortcoming proved a fatal blow to the wider application of moral treatment.³ Thus, the small patient-staff ratio asylum, gave way to overcrowded, distant state hospitals that offered dehumanization rather than moral treatment.

Community Mental Health—First Stirrings

Like moral reform the community mental health movement received its first encouragement from the professional community. Such innovations as chemotherapy and open hospitals were important steps toward community-based services. In our unconscious we tend to equate mental illness with violence. The psychotropic drugs, which could control some of the psychotic behavior made the patient more acceptable and less frightening within his family and community. These advances in patient management were followed by enabling legislation in several states which gave support to decentralization and to changes in the function of the isolated custodial hospital. While community mental health has not had a leader with Miss Dix's continuity and vigilance, it did for a time have generous support at the highest levels of American government. This interest was stimulated by the Report of the Joint Commission on Mental Illness and Health, *Action for Mental Health* in 1961. More than a hundred years after President Franklin Pierce vetoed a mental health land grant proposal, President John F. Kennedy's message on mental illness and mental retardation opened the door for new developments which inevitably led to the federal program for comprehensive community mental health supported by grants for the construction and staffing of mental health centers. Although the staffing and construction legislation (PL 88-164 and PL 89-105) was preceded by a planning effort in all fifty states, there was little flexibility in the federal service model which embraced "comprehensiveness."

Relevance of the Comprehensive Model

Comprehensiveness is one of many romantic notions upon which the community

mental health movement is predicated. When officials of the federal government gave support to Caplan's public health model they spoke of five major service components, which presumably would handle everything from trivia to problems of great magnitude. Comprehensive community mental health services, has been defined to include "consideration of all age groups, all clinically-defined problems, urban, suburban, county, area, state and national divisions or subdivisions as well as preventive, therapeutic and community elements.⁴ Theoretically, the five major service components * were to be adapted and adjusted to meet local needs, though the federal government steadfastly insists that all five elements be included without regard to local resources.

In some communities raising the standards of mental health may require a commitment to social action that greatly outdistances the goals of comprehensive community mental health as defined by the federal government. Enhancing the physical and mental well-being of the population of some communities may require raising the subsistence level, providing decent housing and effective schools. Thus, preventive programs far beyond the expectations of the five components of service may be needed. Mental health professionals must address themselves to the disconcerting features of our national life including the fact that many children experience deprivation even after they are known to and given what is termed "assistance" by human service agencies. In this country more than two million children are supported at levels below the poverty standard by Aid to Dependent Children. Another 250,000 who are supervised in foster care

situations continue to deteriorate.⁵ Marshalling current resources and techniques to meet the urgent problems of these children is a critical challenge for mental health professionals, which, unless monitored, will go unheard at the comprehensive community mental health centers.

In examining the forces that brought the Community Mental Health Centers Act into being, one cannot overlook the stirring newspaper exposés which pointed up deplorable conditions in state mental hospitals. In many instances there was a repetition of the themes sounded by Dorothea Dix. If community mental health has had its "guardian angel" in the twentieth century it has been Mrs. Mary Lasker, patron of what Elizabeth Brenner Brew, writing in the *Atlantic Monthly*, called the health conspiracy. Mrs. Lasker's National Committee Against Mental Illness which is run by fighting lobbyist Mike Gorman has been a potent force in promoting legislation, not only on a national level but in the various states as well.⁶

The mental health lobby and the legislation that brought about the community mental health center concept spoke of service networks which envisioned mental health agencies working in concert with a variety of health and welfare resources. Underlying this idea is a naïve assumption that all charitable institutions have altruistic aims to do "what is best for all of the people all of the time". Elaine Cumming⁷ has likened the delivery of mental health services in the United States to a pinball machine where all of the individual spheres move in their own orbits, though in the same general direction. Understandably, private agencies are concerned with expansion of their own particular domain for in the main, they want to enhance their own operations. The same pattern of operation applies to a number of public and private

* Outpatient, inpatient, partial hospitalization, emergency, as well as consultation-education.

hospitals as well as other health and social welfare services that have received federal mental health center grants. They may embrace the Federal service guidelines more in the spirit of "what's in it for me", than for the good of the masses they have been funded to serve. The federal planners seemed oblivious to the inherent parochialism of health and welfare agencies as they postulated a national mental health plan.

With so many staggering problems close at hand is it any wonder that laymen and professionals alike are alienated by vague references to "eliminating mental illness"? While prevention may require different resources and new organizational patterns than those used by agencies providing direct services, it is possible, we believe, for the

If a modern day Dorothea Dix is on the scene, she is yet to be identified. In the meanwhile, the movement depends on the limited appeal of professional organizations and the health lobby.

mental health community to move with dispatch toward specific and tangible goals, leaving illusory references to "total mental health" and "universal happiness" to the sloganers.

The idea of "organizing communities around mental health needs" merits a closer examination. Mental health professionals have generally accepted this goal when they speak of a public mental health system sanctioned by local government with the tacit and active support of a broad base of community leadership. It is both self-serving and arrogant to make such an assumption. In many communities mental health is not the priority for local government or local leadership. In communities where such "organization" is possible it

may not be wise social policy, for once the glamour and romance of the mental health movement wear off, the local support and "organization" could easily be shifted to cancer, heart disease or a variety of other problems in the human organism. Rather than fragmented efforts which encourage diffusion, mental health professionals might better work for a total health and social welfare program, of which mental health is a significant component. Without a coherent and systematic public policy for human services many of the goals of community mental health, in our opinion, will not be attained.

Currently floundering without a meaningful overall public policy, mental health centers are further confused by the lack of guidance in establishing primary goals. In many instances this has led to the blurring of goals and achievements with the assumption being made that visionary aims are easily transformed into reality. This confusion of goals and achievements is evident to anyone who makes site visits to community mental health centers or pursues their annual reports.

Needed: A Charismatic Leader for Mental Health

Because comprehensive community mental health is an idea with merit, the romantic assumption is made that it will be embraced by community leadership and potential patients as well. Without inspired leadership, like that provided by President Kennedy, the movement cannot hope to move into ascendancy. Social movements require dynamic, passionate leaders and the psychiatric community has done little to fill the current void. Needed is a Schweitzer-like figure with the fervor of a Martin Luther King, Jr. and the sound psychiatric approach of the Brothers Menninger. If a modern day Dorothea Dix is

on the scene, she is yet to be identified. In the meanwhile, the movement depends on the limited appeal of professional organizations and the health lobby. Even with inspired leadership the comprehensive community mental health movement will have to deal with the pervasive American value system which often runs counter to long-range social planning. The rugged individualism tradition is inconsistent with many of the operational necessities of community mental health.

With its lack of clear definition . . . the comprehensive community mental health movement faces many of the same crises which brought about the downfall of moral management.

Yet, assuming that this barrier could be overcome by persuasive leadership, how, even with sophisticated methods of planning and computer technology, could the unstable and changing nature of the environment be programmed and planned for? For example, no planner five years ago could have foreseen the prevalent drug abuse problem among college students or the debate about treating alcoholics stirred by the recent Supreme Court ruling on the Powell Case.⁸ It is yet to be determined just how rapidly the community mental health center can respond to such urgent and previously unforeseen needs. However, since most community mental health centers operate on a modality-oriented programmatic model that tends to reject certain patients as "inappropriate", it is doubtful that this can be achieved.⁹

Cooperative community mental health programs are feasible, but compacts between the main purveyors of service, rather than a random group of local leaders, must be entered into. It is naïve to assume that

the community mental health center will have a significant impact on the power structure of a local community.¹⁰ Goals must be defined and targets narrowed both in terms of patient populations to be served as well as liaison with specific target communities. Without such an approach there will be a danger of the same kind of generic, global tasks that have wrought havoc for so many social movements intent on improving the lot of mankind. The mental health professionals should stop emulating the Statue of Liberty opening her arms indiscriminately to the "huddled masses". Instead, careful setting of priorities with some built-in opportunity for success and evaluation must be pursued.

By pursuing tangible, overt problems first, the professional will have the necessary success experiences and be able to deal with some of the more subtle pathology of communities. However, to embrace the massive tasks outlined in the full application of the public health model to mental health is folly. There have been glimmerings of hope here and there with an occasional explosion of brilliance in the community mental health field. Yet, in each instance goals were more carefully stated and the mission refined . . . and even then success was not always remarkable. In a recent examination of ten innovative studies, Jack Elinson wrote, "it is not an unduly harsh judgment to make when I say that none of the ten programs of social intervention achieved striking positive results. There are glimmerings of a positive and meaningful effect to be observed here and there, possibly the effects where there are any, are slight, and in a few instances there are some negative effects."¹¹ Such verdicts are not uncommon in reviews of broad-based community oriented programs, most of which are usually organized to do all things to all people, which is the equivalent of doing nothing for anyone.

With its lack of clear definition and a tendency to attempt to solve a wide range of problems, the comprehensive community mental health movement faces many of the same crises which brought about the downfall of moral management. The lessons of the past are clear and perhaps we can avoid the obvious pitfalls through positive action toward reasonable goals.

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Doris A. Berlin, M.D., M.P.H.

Mental Health In and Out of Public Health

The author presents a historical view of the development of the fields of public health and mental health on the federal and state-local levels. Throughout our history mental health has had a much closer relationship to public health on the federal than at the state level. It is suggested that there be more coordination of services at the state and local levels and examples of such cooperation are given. Aftercare appears to be the program area with the greatest possibility for coordination between these two fields. Mental health education and alcoholism programs would also benefit. Overlapping appointments to Boards of Health and the Community Mental Health Services Boards would increase cooperative programming at the local policymaking level.

Mental Health and Public Health

Mental health and public health are essentially similar areas of human endeavor. Both fields are involved in disease prevention and health promotion as well as in the treatment of illness. Millions of people are being cared for by the various clinic and hospital facilities available in public

and mental health. Both fields foresee severe manpower shortages in the future while presently employing large, though insufficient, numbers of professionals and non-professionals.

Mental and public health, then, are basically alike except that physical well-being is the concern of the latter, and mental and emotional well-being the province of the for-

At the time this paper was written, Dr. Berlin, a psychiatrist, was a research associate in public health administration at the University of Michigan School of Public Health. She is now Director of Education, Toledo State Hospital, Toledo, Ohio. 43603.

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mer. It is in the pattern of administration of services that these two fields are found to differ considerably, both historically and in the present.

In the majority of states, mental health is located in a separate administrative agency from public health. One cannot but wonder how it came about that two such similar enterprises run on different, sometimes parallel, tracks, as it were? In some instances, they scarcely seem to know of the existence of the other.⁶

History gives some clues as to how this administrative separateness came about. The discussion that follows will confine itself to the development of state and federal government services. Voluntary agencies, though contributing a great deal to the development of government agencies, will not be dealt with here.

History

Federal. Mental health has always been in public health on the federal level. Although born as the Marine Hospital Service and reared, so to speak, in the Treasury Department for 140 years from 1798, public health first was officially so named in 1912. It was not until 1939 that the Public Health Service of the federal government came of age as part of the Federal Security Agency. Only 9 years before, mental hygiene had been born as a legitimate offspring of the Public Health Service. This mental hygiene division was given a big shot of growth hormone in the form of the National Mental Health Act of 1946, which elevated it to the status of one of the National Institutes of Health.

In 1953, the grandfather Federal Security Agency achieved cabinet status, becoming the Department of Health, Education, and Welfare. The Public Health Service grew, but so did its progeny, the National Institute of Mental Health. After consultation

with the experts on the "health" of mental health services, the Joint Commission, President Kennedy, and Congress came up with more growth hormone—sometimes also called appropriations—in 1963 and in 1965.

The parent field of public health wasn't growing quite as rapidly during the mid-1950s. There were many who tried to give it an appropriate injection in 1965 in the forms of Titles 18 and 19—but the vein was missed and a social security agency got the injection instead. In 1966, though, the comprehensive health planning act was passed, as were the regional medical programs for heart, cancer and stroke. Public health indeed grew bigger, with lots of room for the blooming National Institute of Mental Health when it was elevated to bureau status.

In 1968 the National Institute of Mental Health and the Public Health Service committed a sort of incest—child married parent—and what has emerged is a new entity, the Health Services and Mental Health Administration of the Department of Health, Education and Welfare.

State-Local. Official mental and public health agencies on the federal government level have evolved largely into fact-gathering and disseminating agencies; they are concerned also with training health personnel and the provision of grants to strengthen services of state and local health agencies.

On the state level mental health seems to have tooted its whistle first—and louder—than public health did. In 1773 the Virginia House of Burgesses opened a mental hospital in Williamsburg. By the early 1800s, however, most mental patients were in chains in jails and almshouses. Their plight evoked the crusading spirit of many. Kentucky constructed an institution for these patients in 1824, and South Carolina in 1828. By 1850, fifteen states had erected such

hospitals.¹¹ On the other hand, the first state public health department, in Massachusetts, was formed in 1869.

The early 1900s saw a spurt in the development of public health, with 38 states having established state departments or boards of health. Soon also, county health departments arose under the principles of local autonomy and initiative in health matters. Of great significance in terms of current development, also, was the notion of the district health center, first developed in New York City in 1915,¹⁶ an *avant garde* concept when considered in the light of such centers under OEO today and the idea of the community mental health center.

During this same period, and continuing throughout the 1930s, many states found they had to erect more state hospitals for the growing numbers of mentally ill—sometimes 10 or more in the more populated states (6 states had a total of 84 hospitals by 1949). Soon, centralized state boards were developed for purposes of uniformity, supervision, and efficiency in management. By 1936, Massachusetts and New York had converted their centralized boards into state departments of mental hygiene. These were still primarily concerned with hospital care of the mentally ill, however. They had no connection with the state health departments.¹¹

In the early 1920s, efforts were made by some state health departments to provide mental hygiene outpatient services. The first was in Connecticut.⁴ Later, Kentucky and Oregon established similar mental hygiene bureaus or divisions in their health departments. Hawaii, a territory then, also developed a mental hygiene bureau. Other state health departments developed interest in the mental health field outside of the hospital aspects, but these were carried out through such divisions as their bureaus of

maternal and child care, as in Maryland, New Jersey and Wisconsin.

By 1919, all the states had created departments and boards of health, but by 1940, only eight states had established departments of mental hygiene.* Still, as mentioned earlier, these state departments were mainly departments for running hospitals for the mentally ill.

In 1946 the previously mentioned National Mental Health Act was passed, providing federal grants-in-aid to the states to encourage the development of local mental health services. It was expected that giving care to the mentally ill in their communities early in the course of their illness would stem the rising number of patients having to be admitted to the state hospitals. The law required each state to designate a "Mental Health Authority" to receive and distribute the funds. It further specified that this Mental Health Authority would be the state health department unless there was another single state agency responsible for administering the state mental health program. Eight states had such a single state agency in the form of a state department of mental health, but only five of these were named the Mental Health Authority.** These departments were the forerunners of the separate state departments we have today, devoted to mental health in its entirety, providing a wide range of comprehensive services, both inpatient and outpatient. Here the integrated mental health program is completely separate administratively from public health.

Twenty-nine of the states designated their health department as the State Mental Health Authority under this National Mental Health Act of 1946. In these, public

* California, Indiana, Maryland, Massachusetts, Michigan, New York, Oklahoma, Virginia.

** Indiana, Massachusetts, Michigan, New York, Virginia.

health had a real opportunity to develop community programs and services for the mentally ill. But, of course, responsibility for hospitalizing the patients was still vested in the state agency managing the mental hospitals. Here, then, mental health would be both in and out of public health. This created a fragmented mental health program with two state agencies being responsible for different aspects of the care of the mentally ill. This separation still exists in 4 states.*

The history of the development of state mental health programs on the community level as a result of the 1946 Act is not too clearly documented. Although many states established mental health clinics in their local health departments⁸ and many state-level personnel were employed to consult with communities and help them establish such programs, various difficulties arose.^{12, 17, 19} Partly these were related to shortages of mental health professionals; this was aggravated by the fact these people were able to obtain higher salaries elsewhere than in health departments. Some writers have mentioned that lack of training or interest in mental health tended to inhibit development of mental hygiene programs in public health.

By 1960, many local health units had mental health programs^{6, 9} and a recent preliminary report suggests that even more have been developed.¹⁸ These have been clearly insufficient to meet the needs, however.

In 1950 a report of the Council of State Governments recommended unification of all mental health services in the state department responsible for mental hospitals.¹¹ This was based on such considerations as the fact that needed personnel were already employed in these institutions, making for

ready availability and needed economy; furthermore, it was felt that development of outpatient departments in these hospitals would tend to reduce their isolation from the communities they served.

Over the ensuing 18 years, state administrative patterns for mental health programming have moved toward the Council of State Government's recommended form; today, in 44 states, there is one agency rather than two responsible for all mental health programs. Nineteen of them are cabinet level state departments of mental health. Only four health departments have become responsible for the complete state mental health program—that is, administering hospital as well as community mental health care. These four, where mental hygiene functions as a division of the department of health, are Georgia, Idaho, North Dakota and Hawaii.⁶

Since 1961, 12 states have removed responsibility for community mental health services from their health departments and have integrated them with hospital programs located in other state agencies. These have not been given departmental status on a cabinet level, however. Many agencies are divisions of such departments of state government as that of mental hygiene and corrections, as in Ohio. In Wisconsin, Minnesota and Pennsylvania, the division of mental hygiene is in the department of public welfare. In Washington it is in the department of institutions.

In 1963 the federal Community Mental Health Centers Act was passed. Money was made available to the states and local communities for the construction and initial staffing of community mental health programs. In many ways these are very similar to local health departments.^{2, 15} Their operating principles are public health concepts; primary, secondary and tertiary prevention are essential components of their

* Wyoming, Mississippi, Arizona, New Mexico.

programs and epidemiological data are necessary for their future development. The catchment area idea, that of serving a circumscribed area, is also borrowed from public health.

To complete this historical review, I might mention two other legislative actions which have a bearing on the relations between public and mental health. The first of these are the 30 or more State Community Mental Health Services Acts. In providing for the appointment of local community mental health boards, very similar to local boards of health, these acts represent measures on the part of the states to stimulate local planning and responsibility for mental health.

The last item of legislation is the Federal Comprehensive Health Planning act by which each of the states will have state and local planning groups develop comprehensive rather than categorical plans for health care programs; the federal law stipulates that 15 percent of the funds must go to the state mental health authority for mental health programs. Here is one way for co-ordination and interaction of hitherto disparate programs, at least in their planning.

Administrative Separation of the Two Fields

From the history of the development of federal and state public and mental health programs, and the organizational forms created to administer them, we can see that mental health has had a much closer relationship to public health on the federal than at the state level and this continues today.

We might ask ourselves what this administrative separation on the state level means in terms of services provided to patients? Fragmentation and gaps in care are

outcomes most often mentioned. A paper by Mandell and Cromack¹⁰ illustrates this quite well in terms of our two fields of endeavor. They studied all patients admitted to a state hospital from one county in a year's time; over 20 percent of these patients had been seen at the county hospital or the health department in the three years prior to hospitalization. And the question can be asked—could not the county hospital or the health department have prevented the psychiatric breakdown, or if not the breakdown, then the hospitalization?

The answer is yes, to a considerable degree. The program of the San Mateo County Mental Health Department in California has reduced the number of mental patients sent to the state hospital by one-third. And a recent study by Pasamanick, utilizing one interview by a psychiatrist for diagnosis and prescribing, followed by public health nurse home visits to patients, prevented hospitalization in 80 percent of the patients.¹⁴

The common objective, to which I believe most of us would subscribe, is that comprehensive health services be available to all who need them. Such services would include the physical, mental, and social aspects of health. Logically, attainment of these goals would seem to require unification of all agencies providing these services. A recent recommendation along these lines is that of the National Commission on Community Health Services; "States should take steps to effect the consolidation of their official health services, including mental health, school health, mental retardation, the administration of medical care programs for the indigent. . . ."

The ideal, unfortunately, is often far from attainable. Radical administrative changes in government organization are not easily achieved nor may they even be desirable. It is to the intragovernmental

forms of coordination that we must look for the bridges to connect mental health and public health.

Bridging the Gap

Coordination of public and mental health has been provided for formally in several states. Notable among these is New York which has an interdepartmental Council on Health and Hospitals, composed of the Departments of Health, Mental Hygiene, Welfare, Education and Insurance. Its functions are to organize exchange of information, to provide for interdepartmental consultation, and to conduct joint studies in health areas concerning two or more departments. Another possible form of coordination has been to combine the departments of health, mental health and welfare into one super department such as the Health and Welfare Agency of California. A similar formation occurs in Kentucky. In Maryland, with separate state departments of mental hygiene and of health, the Board to which both report is the State Board of Health and Mental Hygiene. The Vermont Plan for Mental Health recommended an Inter-agency Council for Human Services.

The program area with the greatest possibility for coordination between these two fields is aftercare. Many state hospitals are now reorganizing to adopt the "unit plan," by which all patients from a given geographic area are put in the same ward or wards. Local community agency representatives such as public health nurses are enabled to follow their patients both into and out of the state hospital unit, and are able to work cooperatively with personnel giving care to the patients while in the hospital.

As of 1964, 12 states had formalized statewide programs for aftercare using public health nurses, and 7 were said to be plan-

ning such programs. Public health nurses were said to be involved in some degree in aftercare programs in 35 states.⁸ As more and more effective coordination, planning and workable patterns of administration for aftercare develop between health and mental health departments, the public health nurse will undoubtedly begin to function more and more in preventing hospitalization as well as preventing re-admission of released patients.

Other program areas where potentialities for most effective interagency coordination and cooperation are favorable are in mental health education; health departments with long experience in health education and with skilled health educators available, may contribute enormously to the educational programs of mental health centers. Alcoholism is a third program area wherein patients are given fragmented care, depending on whether they have alcoholic psychosis or alcoholic cirrhosis.

The recent policy statement on mental health of the American Public Health Association recommends that, wherever possible, the new community health centers be based in a general hospital or health center, and that the area served correspond in whole or in part with public health administrative units. Such geographic sharing of facilities and of patient responsibilities cannot help but further the mutual knowing that will lead to more areas of informal and formal cooperation on the part of the personnel of both fields of endeavor.^{1, 18} At the local policymaking level, opportunities for cooperative programming may be enhanced, also, when overlapping appointments are made to the Board of Health and to the Community Mental Health Services Board, or when the director of the health department is also appointed to the Community Mental Health Services Board.

We're all committed to the same goal.

In public health and in mental health, we can build shuttle lines for patients to travel from one service to another. They call these things mergers in railroading and such activities can bring forth actions called suits; in public health and mental health they can only result in pursuits—the successful pursuit of truly comprehensive health services.

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Robert A. Apostol, Ph.D.

John H. Halcrow

Personality Characteristics of Mental Health Center Patients Classified by Referral Source

Review of the Literature

The emergence of a community mental health model⁶ has brought about a re-examination of policies and procedures relative to mental health center administration. For example, Schofield,⁷ in a report on admissions criteria, advocates admission of those who are referred for reasons of mental illness but not those who are referred because of some temporary situation that is causing unhappiness. McPortland and Richart⁸ found that nearly one-half of all patients treated at a mental health center were readmitted within a four-year period. They proposed that revisions be made in readmission procedures in mental health centers.

The referral process has also been studied recently. Bentz¹ in an investigation of the educational background and referral role of ministers suggested that ministers with less education are more willing to try to cope with "serious" cases than are better educated ministers. Zolik and Stotsky² found a trend on the part of those in their study to refer close friends or relatives ("ego

involved") to lay therapists, and to refer people with whom they were not close ("non-ego involved") to professional therapists. Fletcher³ observed that people are more apt to refer someone for psychiatric treatment if they consider him unable to be responsible for his condition than if they consider him unwilling to be responsible. Blackwell² discovered a resistance on the part of upper middle class adults to admitting physical and psychiatric dysfunctions because of their strong feeling of responsibility for coping with conditions by themselves.

Generally, studies of the referral process suggest that those who refer to a mental health center are influenced in this process by their own attitudes, values, and level of appreciation of what mental illness is all about. One might hypothesize a tendency on the part of those in broad referral categories (e.g., clergy, physicians, self and relatives) to refer people with certain types of illness, levels of psychological disturbance, or characteristics of personality. The present investigation addresses itself to this general hypothesis; the design attempts to determine if personality differences exist between patients referred to a mental health

Dr. Apostol and Mr. Halcrow are in the Department of Counseling and Guidance, University of North Dakota, Grand Forks, North Dakota 58201.

center according to referral source. The hypothesis that this study tests is that no such differences in personality exist between these patients.

Method

Subjects

Subjects for the study were former patients of a community mental health center in the upper midwest which provides the usual services for several predominantly rural counties.

All case folders of terminated patients who were seen sometime between October 1965 (the date that the center opened) and November 1968 were examined for possible inclusion in the study. Two major conditions governed the selection procedure. Only patients who had been referred by themselves or relatives, by physicians, or by members of the clergy were selected. Moreover, the case folder had to contain the results of the Minnesota Multiphasic Personality Inventory (see next section). Subjects for the study, therefore, were placed into one of three referral categories: Self and Relatives; Physicians; and Clergy. Referrals from these sources comprised the majority of the center's caseload for the October 1965 to November 1968 time period. The numbers of cases in the other referral categories (schools, county welfare, courts, etc.) were too small to be included in the study.

This selection procedure assigned 66 patients, 27 males and 39 females, to the Self and Relatives category; 109 patients, 37 males and 72 females, to the Physicians category; and 54 patients, 25 males and 29 females, to the Clergy category. Chi square analysis shows that no statistically significant relationship exists between referral category and sex ($\chi^2=2.23$, $p>.05$ for 2 degrees of freedom).

Instrument

The Minnesota Multiphasic Personality Inventory⁴ was utilized to measure personality characteristics. At this center, the MMPI is usually administered to those in the above three categories prior to the first therapeutic interview. All case folders selected for the present study, therefore, contained the results of the MMPI. Many MMPI scales have been constructed, but the present study utilized only the usual 10 clinical scales, and the L, F and K validity scales.

Statistical Treatment

Means and standard deviations were calculated for men and women separately for each referral category. One-way analyses of variance were applied to the data for each sex to test the hypothesis of no significant difference between the means of each referral source. This procedure was performed on the L, F and K validity scales, and on the 10 clinical scales—a total of 13 analyses for each sex. The .05 level was established as the criterion for significance.

Results and Discussion

No significant differences on any of the analyses were found; the hypothesis of the study, therefore, could not be rejected. The conclusion is that no differences in personality characteristics exist between patients who are referred to this mental health center by those in Self and Relatives, Physicians and Clergy referral categories.

Clinical examination of the MMPI profiles suggests that there is considerable variation in personality (and in personality disturbance) among those in each referral category. This finding is related to the report by Bentz¹ who found that better educated ministers refer serious cases for

professional treatment but ministers with less education try to treat serious cases themselves. Differential referral practices of this sort could cause wide variation in personality characteristics among those who are referred. To apply the same general reasoning, it might be hypothesized that those who are less sophisticated about mental health are inclined to treat seriously disturbed people themselves whereas those who are more sophisticated usually refer these people for professional treatment. Or perhaps the relationship, if any, between mental health sophistication and referral practice is more complicated than that. A study of factors which contribute to the wide variation in personality disturbance among patients referred to a mental health center would seem to be indicated by the results of the present investigation.

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Patricia Keith-Spiegel, Ph.D.

Harry M. Grayson, Ph.D.

Don Spiegel, Ph.D.

Using the discharge interview to evaluate a psychiatric hospital

Methods used to evaluate mental hospital treatment programs often neglect the voice of the group most deeply involved with program effects—the patients themselves. What aspects of hospital life do the patients perceive to be of greatest benefit to them? What about the hospital is viewed as least helpful or even detrimental? If patients themselves are asked to offer suggestions for improving treatment and hospital conditions, what do they want to see changed?

Method

A total of 360 consecutively discharged patients from a large neuropsychiatric facility were individually interviewed on the day of their exit into the community.* The

The authors are affiliated with Brentwood Hospital, Veterans Administration Center, Los Angeles. Reprint requests should be addressed to Dr. Keith-Spiegel at 15374 Longbow Dr., Sherman Oaks, Calif. 91403.

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purpose of the interview was to assess opinions about treatment and hospital conditions.

After the purpose of the interview was explained and rapport established, the following three questions were asked: (a) What did you like best about the hospital? That is, what helped you the most?; (b) What did you dislike about the hospital? That is, what helped you the least?; and (c) Do you have any suggestions for improvement in hospital programs or functioning?

Patients could give more than one response.

Results

General good treatment was the category mentioned most often (28%), with food as the next most popular (23%). Next were: staff in general (21%); medication (20%); recreational activities (20%); work detail as-

* The interview technique was a modification of a method suggested by Dr. Grace Surber in her article, "The exit interview," which appeared in the September, 1962, issue of *Mental Hospitals*.

signment (17%); work therapy and training (17%); treatment physician (13%); and nursing assistants or aides (10%). Eight percent found nothing beneficial, while 7% liked the nurses, the kindness shown by the staff, the security of the hospital and the fact that this hospital experience was better than previous ones. Five percent liked the companionship of other patients, the privilege cards, and the help with self-insight. In the lower percentiles were such items as group therapy, social work services, religious programs, library, patient meetings, movies, etc.

Almost a third had no suggestions for improvement of hospital programs.

In regards to their dislikes, 22% found nothing to pinpoint. Ten percent felt they didn't see the doctor often enough and disliked the locked ward. Being confined was a gripe of 9%, while 6% disliked the long cafeteria lines. Five percent criticized the overcrowding and general poor treatment. Lower percentages were bothered by boredom, the staff's lack of interest in patients, too much red tape, group therapy, having to get up so early, noise, having very sick patients mixed in with less disturbed ones, electroshock treatments, sitting around all day, medication, etc.

Almost a third (30%) had no suggestions for improvement of hospital programs. Four percent wanted more evening activities, more activities for locked ward patients and more therapy by the treatment physician. Others (3%) felt that highly disturbed patients should be segregated, more staff members were needed and meals should be less rushed. Fewer wanted such items as better food, more passes, more trips, better movies, etc.

Discussion

Beneficial Aspects

Most patients were able to make a definite decision regarding the most beneficial aspects of their treatment whereas only a small number (8%) felt that nothing was of special benefit to them. Of particular interest was the high percentage of patients who chose food as the most favorable aspect. When the interview transcripts were examined, it was noted that many patients said that they either did not eat regularly or that they did not have enough to eat while on the outside. The psychiatrists as a group received substantial credit as might be expected. The nursing assistants were also mentioned frequently; more than nurses and considerably more than social workers and psychologists. Recreational activities and programs oriented around work and job training were also often viewed as helpful.

Noticeably infrequent among the favorable comments about the hospital were those about the role of the hospital in providing a favorable atmosphere or setting in which to recover from their illness. Attention was primarily focussed upon the formal services and physical setting (or "hardware") of the hospital rather than upon an analysis of the roles of the staff in assisting patients or in facilitating treatment.

The fact that so many patients mentioned food, medication, recreation, general good treatment, rest, kindness, etc. as among the most beneficial aspects of the

Many patients said that they either did not eat regularly or that they did not have enough to eat while on the outside.

hospital may suggest that what pleases patients most is the way the hospital meets their dependency needs. It is also noteworthy that most of these items could presumably be provided outside the hospital.

Negative Aspects

Although many patients did not offer negative comments about their treatment, major dislikes centered around confinement and conditions stemming from the typical problems associated with too few staff members to handle a large patient load. Only a small number of patients were dissatisfied with rules and regulations, the physical facilities, patient fund allocations, or particular staff groups.

Improvement

Many patients (30%) offered no suggestions for improvement. Few patients suggested ideas for new programs which would assist them with their reintegration into the community. However, the authors were impressed with the reasonable and clever suggestions offered by some patients, many of which would be relatively easy to implement. Several staff members commented informally to the authors that unless some of these items had been called to their attention, they would have gone unnoticed by the staff. For example, volunteer programs revolving around patient ideas have been adopted as a result of a suggestion made in this survey.

This survey raises questions concerning the role which patient opinions about hospital care and treatment should play in the

improvement of hospital treatment programs. To what extent are treatment goals impaired by failure to take into consideration aspects of hospital routine which may be extremely frustrating to many patients? In what ways may the large treatment institution unwittingly fail to meet the best interests of the patients by lack of sensitivity to patient needs? What findings have emerged from this survey which should be given serious consideration in hospital improvement programs? Perhaps hospital administrators should give particularly serious consideration to those responses of patients which do not jibe with their own perception of the hospital system's strengths and weaknesses.

Summary

Consecutively discharged patients ($N=360$) from a large neuropsychiatric facility were interviewed in order to assess attitudes towards their treatment while at the hospital. The most frequent aspects of the hospital which were seen as beneficial were "general good treatment", food, staff in general, medication, and recreational activities. The treatment physicians and psychiatric nursing assistants were the specific personnel groups mentioned most often as helpful. The most frequent dislikes included not being able to see the doctor often enough, locked wards, and various situations associated with having too many patients for the available staff and facilities (e.g., chow lines too long, wards too crowded, etc.). More general interpretations of attitudes of patients towards psychiatric treatment were discussed.

Martin Strickler, A.C.S.W.

Betsy La Sor

The concept of loss in crisis intervention

The authors see loss as basic to all crisis situations. They define and illustrate three types of adult losses—self-esteem, sexual role mastery and nurturing. The ability to identify the kind of loss in a particular crisis enhances the preventive goals of crisis intervention.

Introduction

Crisis intervention has been steadily gaining in popularity since Gerald Caplan and Eric Lindemann first began describing the phenomenon of crisis. The usefulness of this work is particularly seen in the prevention of hospitalization of the individual.³ Crisis, however, provides both special motivation and opportunity for a distressed person of any psychological, social or cultural level to attempt new ways of coping with particular life hazards.⁶

Caplan describes the crisis situation as involving a "relatively short period of psychological disequilibrium in a person who confronts a hazardous circumstance that for him constitutes an important problem which he can for the time being neither

escape nor solve with his customary problem-solving resources."¹ Intervention consists of assisting the individual in solving this current problem by learning other and hopefully healthier ways of coping with the circumstances. Crisis intervention treatment, therefore, focuses on the immediate problem situation, not on long-standing pathology or well-established character patterns.

A trainee in crisis intervention must become accustomed to several alterations in his usual style of therapeutic assistance. Detailed assessment of the crisis requires clearcut determination of: (a) the actual precipitating event that transpired within the past few weeks; (b) the hazard or threat to a significant relationship or social role that emerged within the process of that event; (c) the loss to psychological needs that confronted the person as a consequence of the hazard (see below); (d) the customary and often very limited range of problem-solving resources or ego coping mechanisms

Mr. Strickler is Deputy Director of the Los Angeles Psychiatric Service—Benjamin Rush Centers, 8770 Whitworth Drive, Los Angeles, Calif. 90035. Miss La Sor was a nurse trainee at Benjamin Rush Centers.

employed to deal with the hazard; (e) the new factors or conditions involved in the recent situation that mitigated against the usefulness of habitual ways of coping with that hazard; and (f) the seemingly insoluble cognitive dilemma that derived from the impasse in resolving a vital life problem, eventuating in a state of crisis.³

Once this careful assessment has supplied the crisis picture the treatment goal is then to communicate to the patient the essence of his dilemma, enabling him to be restored to an emotional equilibrium and to be ready for problem-solving.⁵

In the beginning contact the individual in crisis can occasionally identify a problem; much more often he can only describe feelings of despair and immobilization in his life. The short time limit of treatment, usually six weeks, and the urgency of the problem demand that the therapist understand and define the crisis situation for the patient in the first or second visit. Without a clear picture of all the elements leading to a crisis, utilization of the crisis intervention model is impossible and the sessions begin to resemble conventional short-term therapy with the focus on pathology rather than on the crisis itself.*

Strickler views crisis as occurring "only if the individual senses that he does not possess available means of coping with the hazard, which is seen consciously or unconsciously as a vital threat to his narcis-

sistic, libidinal or dependency needs and supplies."⁴ He has found that in every crisis three basic kinds of psychological needs are threatened to some degree; in each crisis situation, however, there is a predominant loss or threat of loss with respect to one or another of these three types of needs. Identifying the major loss suffered in a particular crisis (point 'c' in the above assessment) can thereby greatly facilitate the overall assessment and intervention. It enables the crisis therapist to have a deeper awareness of the conflict or dilemma the individual is feeling and the reasons why previously used coping mechanisms are not sufficient to deal with the hazard.

This paper will define the three types of losses to which any adult in crisis, regardless of his level of mental health, is vulnerable. Following these definitions, case material will illustrate the predominant loss in each of three crisis situations and the value of this knowledge to the intervention.

Loss of Self-Esteem

An individual enhances or bolsters his self-image and feelings of worthiness by receiving external supplies of recognition. A loss of self-esteem occurs when the person suddenly feels unable to maintain a sense of sufficient validation or confirmation of his self-worth. To a considerable degree this validation is dependent upon his ability to perform well in certain specific social roles or relationships; they are endowed by the individual with special importance on the basis of personal, social and cultural determinants in his history. A crisis can be triggered if the person's usual problem-solving resources are insufficient to protect the vital sources of external recognition required to supplement his inner sense of work.

*The Benjamin Rush Center, the Crisis Division of the Los Angeles Psychiatric Service of Los Angeles, has developed the theoretical and clinical model for the Individual or Specific type of crisis intervention as distinguished from the generic model of crisis intervention. (See Jacobson, Gerald F., Strickler, Martin, and Morley, Wilbur E., *Generic and Individual Approaches to Crisis Intervention*, American Journal of Public Health, Vol. 58, No. 2, February, 1968.

Loss of Sexual Role Mastery

In both sexes the ego has to arrive at an inner decision or solution regarding the level and type of success that the individual can comfortably attain and retain in the adult male or female role as defined by a society or sub-culture. Success in the adult male role is principally perceived in the larger American society in terms of performance in vocational and heterosexual areas; the adult female role is mainly assessed in terms of success in maternal, heterosexual, and (increasingly) vocational areas. A loss of sexual role mastery occurs when a change in a significant relationship or role challenges or confronts the individual with the need to perform at a qualitatively new (higher or lower) level of success than he can accept in one or another of these areas.

The crisis intervention approach concerns itself with the various coping devices that the ego employs to provide and sustain "safe" compromise levels of investment in one or another area of the adult male or female role. A crisis may ensue when a situation will not permit the individual to function with the same relative sense of well-being he had previously enjoyed in a particular area of sexual role identity.

Loss of Nurturing

One of the major anxiety contents of life is the loss of love. A prime need of human beings is to be nurtured, and this requires the adult to find his own comfortable balance in the inter-relatedness between independence and dependence. Not only does our society provide less with each succeeding generation in the way of extended family emotional and social supports, but it continues to emphasize the values of independent strivings, competitiveness, and self-reliance. The problem that this engenders

with respect to the need for nurturing requires the use of various ego mechanisms, such as projection and identification, sublimation, and forms of altruism, as well as conscious ego coping in particular social roles and relationships. The threat of loss of nurturing arises when a life event confronts the individual with actual or fantasied loss, or prospect of loss, of a nurturing object or role. A crisis state can then ensue if the habitual ways of coping designed to deal with such a threat are felt to be inadequate to perform this task.

Case Study of Loss of Self-Esteem

Mrs. A, a 36-year-old divorced woman, came to the clinic to get help for her 16-year-old daughter. Joan was presenting a problem at home and particularly at school of increasingly uncooperative and disrespectful behavior. In describing this current situation it became evident that Mrs. A was herself in a state of crisis. A brief historical assessment revealed a series of stressful family events with which Mrs. A apparently had adequately coped until recently.

Mrs. A appeared youthful and attractive. She complained of feeling very weak and overwrought because of the behavioral problems her daughter was displaying. Currently Mrs. A was a student on scholarship at an excellent private music school. The family had been managing financially without a man for some years, with Mrs. A holding a number of low paying but difficult jobs. She could feel comfortable about her marginal breadwinner role, but any threat to her ability to maintain the image of student or promising musician had always aroused the greatest anxiety in her. Mrs. A had sustained herself for many years with the gratification she derived at being an outstanding student in her necessarily protracted, part-time higher educational pursuits.

One month before Mrs. A came to the clinic she found she could not work and also keep up her school work; she stopped working and had been drawing on a moderate amount of savings. Her decision to give up her job required the family to live within an even tighter budget. The problem with Joan began at about this time. Joan expressed resentment about a cut in

her allowance and her no longer being able to keep up socially with her friends' social activities or clothing fads.

Because she had always worked before, Mrs. A felt she had been able to cope with her daughter's occasional unruly and demanding behavior with a combination of firmness and small gifts. Also, any conflict between the dual role of mother-student had apparently been inwardly justified by her hard-earned weekly paycheck. Although Joan's behavior seemed to require additional parental control, Mrs. A now felt a sudden and unusual powerlessness to exercise any control over Joan.

The therapist pointed out to Mrs. A the dilemma she was feeling, namely, that if she would continue with school while unemployed she could not cope effectively, in ways familiar to her, with Joan's needs and demands, but if she would go back to work she would again find that it would seriously interfere with her studies. The importance to her of her professional career was especially recognized in terms of her feelings of self-esteem. However, her sense of failure as a mother, which resulted from Joan's school misbehavior following Mrs. A's quitting her job, seemed to require her to sacrifice the professional plans that meant so much to her.

With the restoration of emotional equilibrium that followed this conceptualization of the dilemma, Mrs. A was able to see that finishing school could greatly enhance the future financial well-being of the family and she could actually provide better for her daughter's own higher educational needs. With this assurance she began again to be appropriately firm with Joan, and to utilize a new type of coping, namely, directly communicating with her daughter about her own needs and the impasse she was feeling. Joan responded to this firmness and communication with improved behavior which in turn reinforced Mrs. A's sense of adequacy in dealing with her. Mrs. A decided to complete her studies and was comfortable with this decision.

Case Study of Loss of Sexual Role Mastery

Mr. D, a 27-year-old married man sought help at the clinic because he was not happy with his life, his marriage, or his wife. Mrs. D, a 24-year-old woman married to Mr. D for two and one half years, was seven months pregnant. In reviewing the history it seems to have been an

unplanned but cautionless pregnancy. During the past three to four months Mr. D had been leaving home in the evening with weak, false alibis, and returning late at night or the next day. Women's letters were "accidentally" found by Mrs. D and in general a pattern of infidelity was evident and not denied by Mr. D. Instead, he would shake his head and say there was really nothing to worry about and that he just couldn't help himself. He handled Mrs. D's nagging, accusing behavior with agreement or withdrawal in the treatment sessions, and by leaving the scene at home.

A clinical picture of Mr. D showed him to be a person whose usual behavior pattern in the marital area was that of a mildly delinquent boy. He had been able, though, to hold creative working positions, had done quite well, and liked his work. His capacity for adult management of household and marital responsibilities, however, seemed fairly minimal. His role of "naughty boy" at home had been permitted and even supported by Mrs. D's readiness to indulge him. He had been able, therefore, to enjoy marital status despite his little boy behavior at home.

Mrs. D had recently posed a serious challenge and threat to Mr. D by demanding that he now recognize he would soon be a father and that he take more responsibility in being "the man of the house." Mr. D began to feel an overwhelming panic that he could not define and it was at that point that he came to the clinic for help.

The problem or dilemma was outlined as involving Mr. D's intense fearfulness in being challenged to take on new responsibilities in the marriage that he felt unable to manage; at the same time his recent efforts to escape this situation were understandably unacceptable to his wife. Mr. D's distress diminished considerably with this conceptualization of the problem. Also, Mrs. D was able to see that this was indeed a critical emotional problem for her husband and not merely a continuance of his usual marital pattern. She began to display her more usual warmth and acceptance of him as a man. Mr. D then found that he could stay at home with his wife and discontinued the pattern of infidelity. This, in turn, proved to be sufficiently reassuring to Mrs. D. After the crisis itself was resolved, a referral to a family agency was arranged to work with the couple until after the baby arrived.

Case Study of Loss of Nurturing

Mrs. M was a 32-year-old married mother of two children, ages three and four. She came to the clinic in an extremely agitated state, feeling sure she had "lost her mind" and half expecting to be hospitalized. She had made a suicidal gesture three days before applying to the clinic by seizing a knife and threatening to stab herself. All this was in the context of a most unusual explosive type of behavior. She had experienced feelings of depression on one or two previous occasions during the past six months when she assumed more responsibility than she felt she could manage. She described herself as unable to say "no" to anyone who had a claim on her and she ran herself ragged helping friends and relatives.

It was with much encouragement and insistent focusing on the therapist's part that Mrs. M could state that she made the suicidal gesture after her husband asked her to continue to engage in certain sexual acts which she found extremely repugnant. She had submitted on several previous occasions but had felt miserable and guilty afterward. She did not share her feelings with her husband. When it appeared that he expected her regular participation in these acts she exhibited the wild, irrational behavior which brought her to the clinic.

Mrs. M explained that she had been brought up in a strict Roman Catholic home and boarded at a parochial school during her adolescence so that her conscience "said" to her that certain sexual acts were sinful and undignified. While her conscience would not permit her to agree to certain acts, she felt that if she said "no" to her husband he would stop loving her.

The therapist pointed out that ministering, and even sacrificing, for others was important and characteristic for her, particularly with regard to her husband to whom she felt so indebted and emotionally needful. However, she recently found she could not in the instance of her husband's sexual expectations be everything he expected her to be because of her religious and moral background, and this presented her with the fearful thought that she might lose his love.

When Mrs. M returned to the clinic the following week she looked and behaved in a dramatically different way. She had color and life in her face and her manner was cheerfully

animated and almost euphoric. She had talked with Mr. M about her problem, after getting up her "nerve." Mr. M had "lovingly" agreed not to make such demands again and said his request hadn't been of such importance to him. She now realized that the imperative command to conform came from "within my own mind."

Summary

The phenomenon of loss is a fundamental issue in all crisis situations. We therefore consider that its particular nature be clearly defined and understood in the general and characteristic assessment process of crisis intervention treatment. This paper has therefore ventured to delineate, define and illustrate three kinds of adult losses: self-esteem, sexual role mastery and nurturing. Case material has been utilized to demonstrate the thesis that even though all three types of losses are involved to some degree in every crisis situation, one of these kinds of losses appears to be predominant and qualitatively more significant than the other two, in the etiology of any crisis reaction. The ability to identify the pertinent kind of loss in a particular crisis enhances the preventive goals of crisis intervention.

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Points of View

Charles E. Goshen, M.D.

Diagnostic Overkill and Management of Psychiatric Problems

Imagine the following case: A 24-year-old married woman and mother of one child appears in the outpatient department of a medical training center stating that she has been amenorrheic for seven months, has noted a progressive enlargement of her abdomen and thinks she might have an abdominal tumor. Initial examination suggests that she is 7-8 months pregnant but she is admitted to the medical service. After ten days of exhaustive diagnostic tests, this presumptive diagnosis appears to be confirmed and a consultation from the Obstetrics Department is asked for. The obstetrical consultant concurs, and recommends that she be sent home until ready for delivery. After discharge from the hospital, review of her records shows that these procedures cost, in hospital days and laboratory tests alone, between \$300 and \$400. In retrospect, it appears evident that the only reason for this substantial expenditure lay in the fact that the patient had not diagnosed the pregnancy herself, but had raised the question of a tumor, leading to elaborate and unnecessary risks, expenses and waste of medical manpower.

Dr. Goshen is a professor of engineering management and associate professor of psychiatry at Vanderbilt University, Nashville, Tennessee 37203.

The hypothetical case mentioned would hardly sound to any group of sophisticated physicians like something that happens frequently in modern hospitals with associated medical schools. Indeed, it might be very difficult to find a single example like this one. Nevertheless, the same sort of thing happens with great frequency in another area. This is the one in which patients with rather obvious (though not self-diagnosed) psychiatric problems are admitted to hospitals for extensive diagnostic work-ups and long hospital stays, and then subjected to psychiatric investigation only as a last resort. The factor which makes this practice so difficult to justify is the high degree of frequency with which this kind of patient is very early suspected of having the very psychiatric difficulties which become confirmed later. Until now, little criticism has been leveled at this brand of medical inefficiency. The demands which society is currently placing on medicine for improvements in its delivery of health care should alert practitioners, teachers and students to this problem.

Little censure is leveled at the practitioner or student who diagnoses pathology which does not exist, but great censure is expected by the one who misses pathology

which does exist. In pursuit of this standard, truly enormous expenditures of facilities and manpower, and not a little risk to the patient as well, are ventured. Many people are not only suspected of harboring non-existent pathology, but are also treated for it, incurring the considerable risk of drug toxicity and surgery.

The type of patients who seems most likely to encounter this kind of practice is the neurotic whose tendencies to translate every sign of discomfort into signs of illness uniquely foster the practice. In fact, these patients often demand this kind of management of their imagined pathology.

The flimsy justifications for this practice of "over-diagnosis" rarely take into account the risks to the patients of subjecting them to unnecessary therapeutic trials and surgery. Instead, they cite only the risks of undetected pathology. The real reasons for the practice, however, are not those commonly given, but are derived from the medical tradition cited above. The alleged professional disgrace of having to face one's colleagues with a record of having overlooked some kind of pathology in a neurotic patient is at the basis of the practice. No disgrace, on the other hand, is attached to the common practice of searching expensively for non-existent pathology or even subjecting patients to the cost and risks of treatment for non-existent pathology.

It could be stated, philosophically, that any physician's mode of practicing medicine—if it is at all consistent—will err either on the side of false positives or of false negatives, and if one of these two choices were more protective of human life than the other, it would be clear that the former would be the one to stress. Unfortunately, however, both entail risks, and statistically, the risks are probably about equal. The mode of practice which errs on the side of the false negative (missing pathology which

exists) is extremely more efficient and less expensive.

Report of a Study

In order to explore in detail the nature and extent of the type of practice referred to, a study was conducted over a five-year period on three groups of patients in a modern medical center. All patients were ones admitted on the inpatient services of the medical or surgical divisions of the hospitals. The first group was made up of those who showed no pathology, but who, after the usual diagnostic medical/surgical work-ups, were referred to the psychiatric service and diagnosed as having a standard psychiatric problem (nearly all psychoneurosis or depressions). The second group was made up of patients having a significant medical or surgical problem, and, in addition, a psychiatric problem. The third group was made up of patients having only medical or surgical problems and not subjected to any psychiatric investigation. In all cases in which a psychiatric diagnosis was made, the patients were referred to the psychiatric outpatient department (OPD) for follow-up treatment and were invariably discharged from the hospital promptly after the psychiatric recommendation was made (indicative of the use of psychiatric referral as a last resort.) In other words, the entire period of hospitalization and its costs were the consequence of the medical (or surgical) investigation, and in no case would the patients have been hospitalized if originally seen by the psychiatric service for psychiatric care. (They were typical OPD types of psychiatric patients. More serious psychiatric cases were less likely to have referral delayed).

The three groups of patients will be referred to as follows: 1. the patients showing only psychiatric problems: P-only; 2. the patients with both medical/surgical and

psychiatric problems: MP-both; and 3. the patients with only medical or surgical problems: MS-only.

The P-only group of patients spent an average of 8.1 days in the hospital, the MP-both group an average of 13.1 days, and MS-only group 11.1 days. The average costs for all hospital charges (exclusive of physicians' fees) was: \$328 for the P-only group, \$538 for the MP-both group and \$445 for the MS-only. These data indicate that the search for non-existent pathology is a very expensive process, and when a medical or surgical problem is accompanied by a concomitant psychiatric problem, the presence of the latter adds substantially to the cost of searching for additional pathology. It must be emphasized that none of these costs were those associated with a psychiatric investigation, or psychiatric treatment. Nevertheless, the patient (or insurance carrier) who pays the final bills will include them in the total, and blame the high cost on the ultimate psychiatric disposition when that was the issue, and not on the fruitless search of the internists and surgeons in seeking non-existent pathology.

The various diagnostic procedures performed on these groups of patients were classified according to: 1. Laboratory; 2. X-ray; or 3. Special (e.g. E.C.G., E.E.G., B.M.R., etc.). The average number of procedures carried out on the three groups were, in the above order: 1. P-only group: 11.0, 3.1 and 1.2; 2. MP-both group: 16.0, 3.2, and 1.4; and 3. MS-only group: 16.9, 2.4, and 1.4. The latter two groups were quite similar in this distribution, and had about 40 percent more procedures than the first (P-only) group. In other words, if both a medical or surgical problem and a psychiatric problem co-exist in a patient, the patient is likely to spend more time in the hospital than if no psychiatric problem is investigated (13.1 versus 11.1 days), but will

be subjected to about the same amount of diagnostic investigation. The difference, then, appears to be one of indecision producing delays in disposition, rather than a search for additional information.

The types of diagnostic procedures carried out in all the three groups were remarkably diversified. Sixty-five different types of procedures were carried out in the P-only group, 54 in the MP-both group and 59 in the MS-only group. Again, this wide distribution of types of procedures appears to be indicative of indecisions and lack of confidence rather than a philosophy of screening out a certain list of prescribed conditions. It seems most remarkable that patients with no pathology are subjected to, not only a similar intensity, but also a similar diversity of diagnostic procedures as those with significant pathology. In many individual interviews with the medical resident in charge of the P-only cases it became apparent that, in spite of the extensiveness and expensiveness of the investigations carried out, at no time was anything other than a psychiatric problem strongly suspected, hence the shot-gun approach to the investigations.

Implications

A fundamental phenomenon lying at the bottom of some of the wasteful practices cited is the common tendency on the part of the non-psychiatric physician to manage those patients he expects to be psychiatric problems in a negative fashion, that is, by proving that "nothing is wrong". Although he perhaps hopes that the negative evidence he accumulates will help reassure his patient, it seems to have, more often, the opposite effect of transmitting his own lack of confidence to the patient. One sound therapeutic principle which can be widely endorsed in the handling of psychiatric

problems is the efficacy of instilling confidence toward the physician in the patient, and this cannot be done effectively in this negative fashion. Neurotic patients tend to be peculiar in a way which can almost be used for diagnostic purposes. They tend to be insulted with the news that "nothing is wrong" (implying they have been faking) and pleased when some kind of pathology is reported (proving them right). Non-neurotic people are more apt to react in the opposite fashion—to be pleased with good news (no pathology) and unhappy over bad news (when pathology is reported). This tendency of the neurotic patient lends itself to a profitable list of imaginary illnesses invented by physicians and patent medicine manufacturers ("low blood pressure", "tired blood", etc.) to match the imagination of the neurotic.

The beginner in medicine will understandably be swayed by the grateful (neurotic) patient who is told that some mythical pathology was found (slightly low metabolic rates, etc.) after other physicians searched but failed to find any. It is important for him to distinguish, however, between the gratitude expressed over a cure and that expressed over a diagnosis. It might be said, in general, that rational patients seek cures and are pleased when one develops, while neurotic patients seek diagnoses and are pleased when they discover one. Perhaps the same criteria might distinguish the rational from the neurotic physicians, as well.

The teaching of medicine has not progressed much beyond the 19th century in respect to the way in which psychiatric problems are regarded in the context of patient management. Then, as now, the tendency has been to reach the conclusion

that a psychiatric problem exists after all possible pathological conditions are ruled out. Unwittingly, this theory forces the conclusion that patients with genuine pathology are never neurotic, and vice versa. Such is not the case, of course. A person's psychiatric status (rational or otherwise) is entirely independent of his state of health, and neither disease nor neurosis immunizes a person against the other.

Instead, it would be more in keeping with the forward march of medical science if psychiatric problems were taught (especially in the non-psychiatric specialties) as problems of thinking and behavior comparable, for instance, to economic problems, or educational problems and should be diagnosed in their own right, and not by a process of exclusion. In other words, it simply is not true that neurosis, for instance, is what remains after all diseases are excluded.

Unfortunately, the prospects of introducing a more sophisticated philosophy into the management of psychiatric problems, as described, is hampered by the very character of the neurotic patient. As mentioned before, this kind of patient continues to look for a diagnosis until some physician finds one for him, even at the price of much unnecessary diagnostic investigation. He is unusually prone to accept extensive treatment, including devastating surgery, for non-existent and mythological pathology. He is insulted with the news that "nothing is wrong" and does not complain about the waste described above. It is easy, therefore, to be popular with one's neurotic patients by catering to these tendencies, and the physician who does not risks a certain degree of unpopularity with them.

Sheldon H. Kardener, M.D.
Marielle Fuller

Violence as a Defense Against Intimacy

Violence and assassinations have been a part of human behavior since the dawn of recorded history. This paper proposes that certain violent acts are neither random nor simply manifestations of man's nature, but are reactions to the misperceived threats of equality and intimacy. In a society which values alienation, the leaders who call us to involvement are likely to be met by violent resistance.

The urgency to understand expressions of violence manifested by urban rioting receives added impetus as we try to cope with the reality of the multiple political assassinations that have erupted on the American scene. In our considerations of these issues, we must not stop short of full investigation by resting the case either on the premise these phenomena are manifestations simply of racial and/or political factors or of classically established psychological factors.

Dr. Kardener is an assistant clinical professor of psychiatry and Miss Fuller is a research associate at The Center for the Health Sciences, University of California, Los Angeles, California 90024.

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We must attempt to formulate newer theories which give added dimension to the conceptualization and understanding of violence.

Contemporary theoretical considerations revolve about the "Nature-Nurture" issue.¹⁸ "Nature" refers to the more classic psychoanalytic consideration that man is born with two major innate drives of sexuality and aggressiveness.⁷ Human relationships are established in order to permit the discharge or gratification of these drives. To date, this theoretical framework has failed to provide a developmental schemata for the aggressive drive as it has for the sexual, leaving aggressiveness the handmaiden of sexuality. Considerable controversy exists regarding the validity of the concept of

inborn characteristics in man, especially among the object-relationists and adaptationists.¹³ This dissent in favor of the Nurture theory is particularly poignant when one considers that man alone (except for unusual circumstances of territorial invasion or overcrowding)¹⁴ subjugates, dominates, "domesticates", and assassinates his own species.

If nothing else, man is a social being who needs human relationships.² During his prolonged nurturing phase, he learns to negotiate relationships using sexuality and aggressiveness as but two of many means of interacting. If this nurturing phase is successful, he develops basic trust and acquires a feeling of surety sufficient to permit authentic, intimate "I-Thou" involvement with others.^{3, 5} To the extent mistrust is the outcome of those experiences with others, he adopts alienation as a means of protection against the anticipated threat of intimate involvement.

Alienation becomes the only alternative to the threat intimacy represents. The status quo must be defended and reinforced against any influence auguring change in the direction of authentic, intimate involvement. Fairbairn coined the term "internal saboteur" to describe this protective stance in the face of such threatened change.⁶

Change has been identified as a prime generator of conflict.²¹ Any person, institution, idea, or nation displaying sufficient potential ability to inaugurate change specifically in a healthy direction (defined for our purposes as the capacity to engage in authentic "I-Thou" encounters) becomes a threat which must be resisted no matter how secretly, longed for is the desire for honest relationships.

Psychosocial Alienation of Everyday Life

Paraphrasing Freud's term,¹⁰ we refer to the daily examples of societal alienation

which, except in their most blatant form, receive little attention and form the condoned, expected mode of human behavior. One example is the commonly experienced ignorance of the identity of one's neighbors, even after years of residence. Observe when next boarding an elevator how we individually obey the covert commandment "Strangers shall not converse." There exists a defensive uneasy tension frequently relieved in laughter if someone behaves contrary to this expectation.

Humor has long been recognized socially for its "ice-breaking" quality, but also psychologically as a way of dealing with painful and threatening truths of human emotion.¹⁰ We suggest that one such truth is the fear of honest, open involvement with others. Psychiatrist jokes are an example insofar as psychiatry represents change in a healthy direction as defined. This is best summed up by the popular bumper sticker reading, "Help Stamp Out Mental Health." The concern by some political groups that mental hygiene is part of a Communist plot is tragically funny.

Jourard¹² has identified how the school system, as a social institution, is used to indoctrinate the young in society's values of resistance to change and automaton conformity. A child learns only when and what he is taught, not for his own gratification, but for that of his teachers and parents. He competes not with his own capacity but against peers, creating a grade-gap between children.

Both the current campus unrest and the earlier hippie movement share youth's renunciation of the lack of genuine involvement perceived in the adult world. However, no matter how honest and worthwhile the search for authenticity may be, these movements are undertaken by those well-schooled, as were their parents before them, in the precious value system represented

by alienation. Youth's sexual mores and use of drugs are two striking examples of this paradoxical reaffirmation of alienation. Random sexual contact often represents a pseudo-intimacy characterized by the merging of genitals only—there are no people involved!¹¹ Drug-taking, while perhaps motivated by an honest endeavor to emotionally reach out and "touch" another, results in the interposition of an alienating third party, i.e., the psychopharmacologic agent.²³

Only the more extreme manifestations of this accepted social edict of alienation and non-involvement shock us into conscious awareness. For example: the Genovese murder witnessed by thirty-nine onlookers who did nothing^a; the man removed from a subway by force and robbed while six sat and watched^b; or the man struck by an auto on the busy on-ramp of a freeway and left mortally injured, ignored by the uncounted numbers of passing motorists in the height of the morning traffic^c.

We read these accounts with shock and horror but never with the understanding that this is exactly the way things are supposed to be, in strict accord with our well-ingrained, rigidly reinforced code of social behavior.

Talcott Parsons states, "The typical Western individual apart from any constitutional predispositions, has been through an experience in the process of growing to adulthood which involved emotional strains of such severity as to produce an adult personality with a large reservoir of aggressive disposition."²¹ We suggest the experience to which he refers is that of alienating relationships. Aggressiveness defends against feared intimacy.

Assassinations

The political arena characterizes the recapitulation of the earliest developmental state in an individual's psychological growth. There is a demand for clear-cut differentiations between parties and candidates. Emphasis is not upon similarities but differences which can then be judged as all good (us) or all bad (them). This infantile need for such dichotomy makes the bad "other" a threat which generates fear. Fear as a basic political emotion has been identified within the expression of concern for security and welfare.¹⁷ Politicians share this same fear as does the rest of society. Lane¹⁴ calls this the "fear of equality" translated into an underlying preference for an inegalitarian society in order to avoid the moral adjustment necessitated by true investment in the fundamental tenets of liberty and equality. Psychodynamically, this is the fear of true intimacy translated into the defense of alienation—implemented by violence when necessary.

The influence wielded by leaders has been attributed to their representing an actualization of some vividly entertained fantasy.¹ If their appeal results in alienation, uninvolvement, inequality, and stimulates fear as well, great support arises! Edelman⁴ identified the role jargon, myths and metaphors play in giving lip service to healthy change, while unconsciously maintaining the status quo. The man who searches for solutions to problems communicates in a language of great emotional impact. He ignites in man the desire to be truly involved. Simultaneously he provokes fear of such healthy change overtly among his opposition but also covertly within his most ardent following.

Regardless of one's theological inclinations, there surely would be general agree-

a Los Angeles Times, March 28, 1964.

b Ibid., June 5, 1968.

c Ibid., February 21, 1968.

ment that the philosophy espoused by Jesus Christ was one of involvement and brotherly love. It is he, and not Pontius Pilate who ends up on the cross. As has been stated, this event, as well as the conspiracy of a disciple, follow logically. Judas metaphorically represents the personification of the "internal saboteur" resisting healthy movement.

Abraham Lincoln was not assassinated during the conduct of the Civil War (a war representing the society's ultimate expression of violence in the defense of alienation). Rather, was shot five days after General Lee's surrender at Appomattox. History records that his plans for peace were flexible and generous, inviting the South to share as equals in the rebuilding of the Union. This was met with resistance and sharp criticism within his own party.

Both John F. and Robert F. Kennedy similarly espoused views urging greater involvement of man with his fellow man. They both conveyed this poignant message with believable emotional conviction. Belief that they could implement this ideal and were not just talking about it, is the essence of what made them such a threat—particularly in the deranged minds of their assassins.

The murders of civil rights workers and leaders, most especially those of Medgar Evers and Dr. Martin Luther King further illustrate this thesis. Dr. King's fervent policy of non-violence is dangerous to both black and white society because what is emotionally perceived is not non-violence, but non-alienation. This arouses the overt opposition of frightened segregationist whites. Covertly within the non-violent movement there also develops a thinly veiled espousal of violence and alienation for exactly the same reasons. Significantly, this phenomenon can occur only if progress is being made through non-violence toward

the sought-after goals. The assassination of Malcolm "X" is a further example. It was not while he was an ardent supporter of Black Muslim separateness that he was killed, but rather when he began to speak out convincingly for the brotherhood of man, regardless of color, that he was shot—by a Black man.¹⁶

This central theme can be followed through many examples of assassinations regardless of what the superficial content of the issue may represent, be it political, racial, or religious. There similarly emerges a commonality among the assassins as clinically evidenced by the life histories of Booth, Oswald, Ray, and Sirhan. They are alienated, withdrawn, rigidly dogmatic, frightened and insecure people threatened by any political movement which dares closeness, equality, and meaningful involvement.

Certain cultures and political systems have delineated mechanisms other than assassination to ward off those threatening to move toward egalitarian involvements. It is of interest to speculate that the British vote of confidence politically "assassinates" a prime minister by immediately removing him from office without awaiting the completion of a term.

Urban Rioting and Civil Rights Movements

Rioting has been most costly to the very people who can afford it the least. It does not seem to make any sense, at least from the usual point of reference. There is little question that the initial impetus leading to the expression of violence is generated by the despair, frustration, and ultimate rage over the conditions characterizing ghetto life. Simultaneously, however, the very identity of the ghetto is dependent upon its alienated, inferior status defined by the

white society. We suggest the self-destructiveness of the riot is a manifestation of the collective black communities' "internal saboteur" operating to maintain the status quo of that negative identity.

A less violent expression of this same paradoxical reaction is seen in the rejection by the black civil rights movement of the liberal white worker's help. An explanation has been advanced that this rejection is a ramification of unconscious sexual fantasies.²³ If this were solely accountable, the rejection would seem more likely to occur initially and not after some progress is made. It is when progress in reaching anti-alienating goals occurs in the movement that unconscious counter-forces emerge, within the movement itself, to reinstate alienation.

Psychiatric Considerations

The definition of health as the ability "to work, to love, and to raise children" we consider synonymous with the capacity to enter into authentic, intimate involvement with another, unencumbered with the distortions of painful past perceptions. No matter how completely an individual may want to move in such a direction of health, clinical experience amply demonstrates a counterposition, termed "resistance," which reflects that person's need to cling to the (even miserable) status quo. This is certainly not because the individual prefers misery, but rather because he perceives the known state to be more secure than the threatening change potentially created by confronting long established emotional mythologies.

Psychodynamically oriented therapies help the patient recognize how he works against his own best interests for reasons which, although once valid, are no longer applicable. All therapies revolve about the

central concept that options are available which heretofore the patient had not considered possible. There also is the intimate relationship between the consultee and another human being, the consultant. Within their therapeutic alliance, especially as the transference relationship becomes mutually understood, there occurs a growing real relationship.⁹

This central issue of the struggle between intimacy and alienation is reflected in the changing picture of patient symptomatology from that classically described at the turn of this century. There are increasing numbers of patients who now present symptoms of an existential dilemma, struggling to abandon defensive alienation in favor of becoming intimately involved.

Suicide may represent an ultimate expression of this struggle. Clinically, suicidal danger in a severely depressed person is greatest when a patient first begins to show signs of improvement. The accepted explanation has been that motoric capacity to carry out the act returns sooner than the occurrence of an altered state of feeling. We would suggest that such suicide may be a manifestation of self-directed violence by the despairing part of the self against its health-seeking part because of the distorted fear that change, in the specific direction of health, will create a worse state of despair.

Conclusion

This paper presents a supplemental thesis that certain violent acts are neither erratic, random occurrences devoid of essential psychological meaning nor are they simply manifestations of man's nature, but rather are vital, treasured—albeit extreme—representations of defensive societal behavior. Such acts become the ultimate expression of resistance to the misperceived threat which equality, intimacy, and authentic human involvement present.

The feared expectation that an intimate encounter with another will result in self-harm is a mythology society perpetuates through its institutions which then act to support alienation. When violence is viewed as a defense against intimacy, man's fascination with and striving for mastery of even greater destructive potential becomes understandable. War, riots, or assassinations of leaders who threaten to take us in the direction of real involvement with our fellow man, are essential to the maintenance of protective alienation no matter how consciously deplored.

By these criteria, manifestations of resistance to meaningful change occur only in a society struggling to be healthy. It is the sick society, stagnant in its status quo, which does not experience these growth pains. Continued growth depends not upon violent acts being met in kind, but rather upon stripping away the sheep's clothing of violence in order to expose the wolf of alienation which devours from within.

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Edith B. Back, M.S.S.W.

The Community in Community Mental Health

The role of the community in the mental health field remains unclear, with part of the confusion stemming from a lack of a clear definition of a mental health community, and of the purposes for which it is organized, as well as the relationship between professional experts and consumers. Experiences of recent years can shed some light on these problems.

Neighborhood councils organized for the purpose of including area residents in the planning of health programs to meet their needs are usually formed after a commitment has been made to provide certain clinical services and major staff positions have been budgeted and partially filled. The councils are not always aware of this and are left to subvert, petition, challenge, approve, assist and advise the work of the experts.

Open-ended attempts to learn the wishes of client groups have at times elicited technically unsophisticated demands, such as doors on closets in the case of planning a model housing project, and rejection of the open ward concept in an instance in the mental health field. The professionals, committed to certain innovations, needed to "sell" their ideas to the consumers. While

such experiences may demonstrate that the inclusion of the clientele in planning hinders the provision of good technical services, they might also demonstrate the need to include the public in the dialogue earlier, so that consumers may choose from alternate arrangements a profession has to offer.

Reissman reported that the Lincoln Hospital Community Mental Health Centers' community aides, under a professional community organizer were trained to respond to whatever problems residents brought to them. These included: "housing, 25 percent; welfare, 22 percent; employment, 23 percent; and family problems, 8 percent". Disposition of cases was: "39 percent information and referral; 49 percent direct expediting."⁴ One might ask how these client concerns are related to the functions of the medical institution given responsibility for the centers.

A neighborhood organization might be conceived of as a vehicle for self-determination and increased political strength, serving to remedy ills of the body politic, in turn promoting the mental health of the participants. It might also be seen as a means of giving voice to patients or potential patients in the planning and delivery of services to meet their needs. The first concept is so broad that it has little relation

Mrs. Back is the Student Unit Supervisor for St. Luke's Neighborhood Health Services Program, 160 W. 100 St., New York, N.Y. 10025.

to the clinical services to which it is bound, while it also carries the danger inherent in the veto power of a special interest group over political activities. The other requires identification of the community of patients, which may or may not coincide with the first.

What's a Community?

Sociological literature abounds with arguments about what a community is.⁸ At one extreme is the ecological interpretation, which regards a community as a geographical entity with inter-dependent parts, economically, socially, and politically self-contained. The ideal model of this school is the pre-industrial, rural village with a town hall form of government in which all participate. Its advocates often bemoan the "loss of community" and plan the creation of small communities, sometimes in the center of large cities. At the other extreme is the view of a community as a point low on the hierarchy of production and delivery of goods and services as well as of governmental power. Branch outlets of corporations or agencies of government have less and less local identity, authority, and accountability, so that the "community" no longer exists. The one point of agreement among the scientists is that a community, whether or not it has a spatial or political dimension, is a group of individuals sharing a set of values and a common sense of identity. The one community, in this sense, to which everyone belongs, at least during some part of his life, is the family, and a community can logically be conceived of as that thing a family carries with it as it moves from place to place.

Whether one's community coincides with those in the neighborhood will depend upon a number of individual and social circumstances. Assuming that everyone in a neighborhood values the same things can

lead to many blunders. People may be voluntary or involuntary members of a neighborhood: they may live in it because they like the people there, because it is convenient to work, because it is cheap, because they were excluded from preferred places. Should one assume that persons who choose the neighborhood and feel a sense of identity and shared values with others in it are more community members than those who dislike the neighbors and wish they could live elsewhere?

Some of the early community activists erred by assuming the existence of an ecological community, in some instances trying to create one. This Utopian approach resulted in a backlash of hostility when the "independent, self-sufficient" communities found their efforts to deal with hierarchies of industry and government frustrating and futile and themselves in reality dependent and subordinate. Another error, romanticizing the life of the poor as a unique culture of shared value and identification with fellow sufferers, overlooked the involuntary nature of poverty, so that many ghetto residents used the opportunities of the poverty programs to detach themselves from those with whom they were assumed to share a sense of community.

The followers of the Parsonian school, seeking to locate or to develop leadership in a neighborhood, operated under the theory of power delegated downward, so that leaders spoke for the others, often the non-joiners, the sick, and the alienated in the area. Neighborhood organizations in community mental health programs composed of persons healthy enough to participate may be seen to embody this concept of delegated responsibility. Only in the area of prevention can such participants, seen in this context as leaders, be regarded as the constituency of mental health programs as currently defined.

Primary prevention is aimed at everyone in a given area, and it takes no level of technical knowledge to know that enough stress will make a person "crazy". Thus, residents of a rat-ridden neighborhood can share a goal of rodent extermination, and they can easily identify with the mother who has a "breakdown" because the rats ran around the baby's crib at night. They do not necessarily identify with her treatment in the hospital, precisely because the treatment is seldom related to the stress presented by rats, and also because she is in the hospital, not they.

In the sense of a community of shared values, then, neighborhood residents might be seen as a community on certain problems and issues while they refuse to be a community on others. One cannot call the non-hospitalized neighbors of patients the leaders who represent the interests of the hospitalized. In several meetings of consumer groups discussing problems of the delivery of health services, I have been struck by the omission of the hospital care of the mentally ill, even in neighborhoods with high rates of hospitalization. In the many complaints voiced about the New York municipal hospital system, the only ones related to the psychiatric wards heard were about friends and relatives "admitted by mistake".

Organizing a Mental Health Community

In order to carry out the mandates of mental health legislation by offering primary, secondary, and tertiary prevention, the "communities" for each of these functions need to be identified within the specified area. Such communities can only be found in the realm of shared identity and value, whether positive and voluntary, negative and involuntary, permanent or transient. The most successful of the social action groups have been those composed of

such communities, organized around common problems. The most obvious examples are in the civil rights, rent strike, and welfare rights movements, all of which, incidentally, transcend neighborhood boundaries.

Clinical evidence shows that certain population groups have high incidences of mental hospitalization, and one of the stated goals of mental health programs is prevention of hospitalization. The high risk groups (in New York these are the aged, migrants, minority group members, never-marrieds, and single persons living alone¹) are often stigmatized and excluded for various reasons from neighborhood circles. (How then can it be claimed that the leaders of these circles represent their needs?) There is no evidence that any programs are addressing themselves to the organization of high risk groups for the purpose of reducing the risk of hospitalization. Organizing in itself would be the first step towards the alleviation of isolation, asking the members to plan the services required to solve mutual problems the first step in removing stigma.

Social group work and group psychotherapy have demonstrated that persons with little else in common can work together around a mutual problem. This can be achieved without forcing people to socially isolate themselves with fellow sufferers, which is the expressed fear of many professionals as well as persons carrying a stigma. (While most professionals would hesitate to form clubs of homosexuals, the homophile movement will probably achieve removal of repressive laws and improvement of the social position of the homosexual while the professionals continue to ponder how to turn them into heterosexuals.) The history of the social welfare movement in this country shows a progression of organizations formed by persons

sharing a need or an ideal. Americans are famous as joiners and respond to invitations to join others if a clear and worthwhile goal is apparent, and if the members do not feel obligated to share all of their lives with others in the group.

Organizing communities of high risk groups would require a combination of skills, an end to the schism between the clinical and the community-oriented professions, and a programmed recognition of the negative effects of environmental stress on illness. Perhaps more importantly, a clear view is needed of what is being organized and why. If the goal is reduction of hospital readmission, groups could be formed of recently discharged patients or persons prior to discharge, for example.

At this point, let us digress to discuss two additional dimensions of the problem of high risk groups: whether hospitalization rates are true indices of illness, and whether the care offered these groups in public hospitals is relevant to their needs. High risk groups are characterized by a lack of the material and social supports which a wealthy person or a member of a mutually helpful social group can count on when in danger of emotional illness. Leo Srole called these supports "reserves," and found them to be very scanty or lacking among those suffering highest rates of mental illness.⁶ Should hospitals plan their services for the treatment of these groups or should efforts be addressed to the creation of reserves? If the latter, it is reasonable to ask whether this is a legitimate role for the medical profession. If the former, the relationship of public hospital care to medical schools must be reexamined. The high risk patient, having no reserves and no choice but the public hospital is seen by a student or resident being trained not to treat such as he, but rather the members of the community with reserves of money, physical

stamina and enough self-direction to keep appointments (no small matter) and engage in a treatment process which might have very little relevance to material and social impoverishment.

Returning to the organization of high risk groups, it is important to recognize that any organizing activity needs to be related to environmental problems. The medical model which treats the diseased entity in the hospital and discharges the patient with instructions to return for follow-up care is as insufficient for the average psychiatric patient as it is for the child who returns to a slum home following treatment for lead poisoning with instructions to his mother to return with him if he has medical problems. Just as families experiencing lead poisoning can be formed into a tenants protest group, so can single men who find life in a flophouse the only possibility open to them upon discharge from a psychiatric ward to which they were admitted following suicide attempts in a flophouse.

Even a simple device for hearing patient grievances is lacking in most hospitals. In a psychiatric ward where people feel helpless, despairing and worthless, and one's future might depend upon making oneself socially acceptable to those holding the power of legal commitment, the availability of a grievance procedure is not only an extension of a decent amenity, but also of an expression of hope and self worth. If patients are seen as a community, albeit transient and involuntary, sharing a common life, space, services, routine, and identity as patient, this sharing can be the basis of a patient organization, a community. Another community to which many patients belong is a family, so that a council of patients' relatives is another community through which the institution can be forced to respond to patients' problems and desires.

The Public as Provider

The poor and the stigmatized have, with reason, regarded traditional agencies as their enemies, and one of the purposes of the early community action programs was the organization of the clientele of these agencies into groups strong enough to confront the technocratic establishment with their unmet needs. Failure to get a response resulted in a shift in tactics, so that we now find groups whose goal is the destruction of certain hierarchies, notably welfare and schools. If the health services system is not to meet similar forces, a means of hearing and responding to public needs is critical. The revelation that federal funds were routed through the New York City Human Resources Administration so that those providing medical services could avoid the requirement of community participation in planning* can only deepen public mistrust and drive the community to militant action.

Voices of the clientele of public institutions are strengthened by the decline of voluntary and the rise of tax-supported services. The term, "charity medicine", still widely used in medical circles, is today not only incorrect but untenable. The public treasury is the major source of funds and the consumer is provider as well as receiver. The public can demand an account from the professionals.

Closely related to accountability is a new kind of competition facing the practitioner. Many ghetto groups have been dominated by middle class spokesmen or persons strongly identified with the neighborhood, who insist upon their roles as community representatives or advocates of the poor and the sick. The experts are faced with

competition for the allegiance of the poor and the sick, and in some instances they are losing the competition. (An excellent example is the work of the Black Muslims with drug addicts.) Such allegiance, now related to public sponsorship, can only be won by a demonstration of concern as well as of the success of the methods of the professionals. Competition then, is shifting from the world of one's peers to the public. Professional activities will become more visible, responsible, and responsive to the public or they will no longer be supported by the public.

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* Statement by Mitchell Ginsburg, Human Resources Administrator, quoted on page one, *New York Times*, January 15, 1969.

Book Reviews

Addiction and Opiates

By Alfred R. Lindesmith, Ph.D.

Chicago, Aldine Publishing Company, 1968,
(revised edition). 295 pp.; \$7.50.

"Ignorance is bliss" could be the title of this book for, the author believes that knowledge is the "hook" in addiction. To Lindesmith, to be physically dependent on narcotics does not necessarily result in addiction. Rather, addiction results when one is aware that the distress experienced is due to withdrawal and that this distress can be relieved by narcotics. The part that knowledge plays in addiction should cause educators to re-evaluate techniques utilized in drug abuse education.

This is a provocative book in spite of the fact that it is rambling in style and a large portion of it is out of date. In spite of its weaknesses, it is a highly readable book, a revision of a classic in the field and should be read by all who want to learn about addiction.

Lois R. Chatham, Ph.D.

Assistant Division Director for Research
Division of Narcotic Addiction and Drug
Abuse
National Institute of Mental Health

Teaching Psychosocial Aspects of Patient Care

Edited by Bernard Schoenberg, Helen F. Pettit, and Arthur C. Carr

New York, Columbia University Press, 1968.
420 pp.; \$8.50.

In 1956 the Department of Nursing and Psychiatry at Columbia University began the use of the teaching model for psychiatric nursing described in this book. The concern of the faculty for strengthening the psychosocial components of patient care through effecting attitude changes in basic nursing students resulted in the formation of a multidisciplinary seminar. The seminar was held jointly with a nursing instructor as the leader, 20 nursing students, a psychiatrist, a social scientist and a nursing supervisor. Nursing students in the seminar were new to their major; however, they had completed two years of liberal arts prior to

entrance to the nursing course. The seminars were held one and one-half to two hours weekly for eight months. This book documents the experiences of those responsible for the project. It is divided into three major areas which the reviewer has labeled parts: (1) Teaching Psychosocial Aspects of Patient Care and the Teaching Unit; (2) Role Relations and Attitudinal Change; and (3) Perspectives in Care. Each of the three sections is followed by a summary and discussion. Many things come under the rubric of "seminar"—nurse-patient interviews, unstructured group discussions, structured groups, agenda groups, lectures, and self-reports by students. Part 1 is essentially a group of papers representative of the disciplines in the seminars, citing problems and experiences in the project. How students perceive themselves and their role partners, a study by Arnold Simmel, is included in Part 2 and offers attention to norm development, value change, and internalization. The four papers in this section reflect the students' gain in self confidence through reduction of anxiety and increase in communication skills. In Part 3, the extension of the seminars to other courses of medical-surgical nursing, maternity, pediatric, and psychiatric nursing is reported. The appendix includes video tape excerpts of the first year seminar, a panel discussion of the video tape summaries of the six workshops of the symposium and a list of participants. An index follows. The table of contents was somewhat difficult to follow. Since there were many authors, summarizers, and discussants, bold face type for the authors would aid the reader. Numerous individuals in the symposium were omitted from the index leaving the reader to search through the section on participants and/or the table of contents.

Many times throughout the book the reviewer empathized with the nursing students as fledglings in a group of professionals and wondered why "multidisciplinary" did not also include students from other disciplines. Much work is needed in this area, while those of the helping professions are students, to avoid the role strains at a later date.

This book should interest the nursing educator, mental health integrator and educators in other disciplines. It is also a contribution to crisis theory, especially in the section "Perspectives in Care". Few nursing programs have truly documented their efforts and methods of

attempting to improve patient-care by the integration of psychosocial aspects. This book should be on the reading list of all those interested in professional standards and the quality of patient-care.

Psychosocial Nursing: Studies from the Cassel Hospital

Edited by Elizabeth Barnes

New York, Barnes and Noble, Inc., 1968.
316 pp.; \$10.00 (cloth), \$4.75 (paper).

Elizabeth Barnes undertakes to describe the longitudinal view of the application of Dr. D. T. F. Main's innovative treatment methods used at Cassel Hospital immediately following World War II. She has summarized twenty years in 28 separate papers by 14 authors. The book is divided into five parts: The Hospital as a Therapeutic Institution; Development of Nursing Techniques; Family-Centered Nursing; Application of Psychosocial Nursing; and Summing Up. An index and complete bibliography follow.

Although the basis of the work at Cassel is described as grounded in part, in group dynamics, I found myself yearning for an individual nurse-patient relationship fully described—a detailed vignette of what happened to one child, one adolescent, one adult, one family, or one staff member. Are we to see Cassel as the opening trumpet for the end of individual nurse-patient relationships and the beginning of a collateral relationship to groups? While quotes from patients were liberally used by some of the authors, an account by a patient of his disorder, treatment and recovery or continuing disorder would have complemented views of the staff.

For the reviewer, to look at aspects of 14 authors is an impossibility—to mention a few takes the risk of omission of pertinent and relevant parts of the Cassel experience. For this reader, the nine papers contributed by Doreen Weddell gave a theme to the book that I held to. Nurses who have experienced radical innovations in a milieu sympathetic to change, who have perceived and analyzed new approaches to comprehensive patient-care, will be right where Miss Weddell is in her 17 years as Matron of Cassel.

Nurses in the U.S.A. now involved in com-

munity mental health nursing may wish particularly to consider those aspects of family-centered nursing put forth in Part III. Observations and emphasis throughout the Cassel experience on the understanding of effects of separation both in the patient and the staff add to crisis theory so much needed in nursing.

Psychosocial Nursing is an excellent documentation of the philosophy, care and treatment of patients and families at Cassel Hospital. It also places articles previously published in diverse journals, within one binding for easy reference.

Frances Monet Carter Evans
Associate Professor and Mental Health Integrator
University of San Francisco
San Francisco, California

The Prison of My Mind

By Barbara Field Benziger

New York, Walker Publishing Company, Inc., 1969. 171 pp.; \$4.95.

Man has often wanted to record how it feels to "lose one's mind", to escape from reality, to find "security" away from the world. Mrs. Benziger gives a journalistic account of her illness. She tells of her treatment, her talks with psychiatric personnel, and her transition from the hospital to the life that she had left.

She has written this book to express her desire to help others free themselves from imprisonment in a sick mind. She emphasizes continuously that she is aware of her illness and seeks the help that others can give her. Some of those are more well-meaning than able. She does find a doctor she can trust and put her faith in, but even then the way back to the outside world is long.

She looks forward to the day when man will understand mental illness as well as he does physical illness. Psychology and psychiatry have made tremendous inroads toward this understanding, but more and more lay people, such as those Mrs. Benziger is writing for, need to become involved and acquire the understanding of the mentally ill as they have of the physically ill.

George M. Schlegel, M.Ed.
Douglas, Georgia

MENTAL HYGIENE

The Treatment of Families in Crisis

By Donald G. Langsley and
David M. Kaplan

New York, Grune & Stratton, 1968. 184 pp.; \$7.50.

At the Colorado Psychiatric Hospital, a research project was undertaken that explores the feasibility of avoiding hospitalization of the identified patient, using family therapy instead to help resolve the stress that is fragmenting the family and precipitating the decompensation before the regression becomes chronic. The treatment and control populations are randomly selected from families seeking for the first time to hospitalize a member who is considered in need of immediate admission. A Family Treatment Unit team, that is on 24-hour call, promptly holds a family session with its treatment families to define the crisis as a family problem and to elucidate a workable statement of the issues. The family treatment includes a home visit within 36 hours, in addition to an average of five office visits, several phone contacts, and collaboration with whatever social agencies may have been previously involved with the family. The first three days of daily contact are gradually reduced, till treatment is terminated after about three weeks, with assurances of available help if and when again necessary. Drugs are freely utilized, particularly in the early stage, when reduction of tension is essential for mobilization of family resources. Referral for more protracted and intensive therapy is made if the individual or family is motivated to work on their long-standing problems, but in any event, the door is left open for return in future crises. There is no hesitation at the start of treatment to take action or give direction to the family members that the team deems necessary to ease the stress, but this responsibility is shared with the family and is rapidly shifted to them.

The comparative statistics of numbers and lengths of hospitalization of 75 experimental families and 75 controls are promising, but little specific statistical analysis is yet reported. It is to be hoped that further analysis of the research data will throw light on the nature of the cases where hospitalization was postponed

rather than averted, for clues to indications and contraindications for crisis family therapy.

From an impressionistic rather than statistical viewpoint, the lucidity of the authors' writing style and format inspires confidence in their treatment method.

This book is an invaluable model of freedom to the family therapist. For the therapist working with individuals who is untrained in the family or interactional approach, it can be a sensitizer to the intrafamilial meaning and purpose of the individual patient's symptoms and behavior. I cannot think of any mental health worker who could not read this book without pleasure and profit.

Tess Forrest, Ph.D.

Great Neck, New York

Manpower for Mental Health

Edited by Franklyn N. Arnhoff, Eli A. Rubinstein and Joseph C. Speisman

Chicago, Ill., Aldine Publishing Company, 1969. 204 pp.; \$6.95.

This is based on the papers presented at a symposium, "Manpower and Mental Health", sponsored by the National Institute for Mental Health. Although the book mentions some new programs in delivery of services, and some new educational approaches, this is not its objective. Instead, there is an attempt to come to an understanding of why there is a manpower shortage in the area of mental health, and, in fact, whether there truly is a shortage.

Starting from an overview of growth and development in the field, it continues through the politics and economics of the subject to conceptual models. There is a stimulating and somewhat controversial presentation of the medical model versus the environmental-behavioral model. Other chapters approach the subject through career trends and motivation.

It is only after this thorough grounding in the total philosophy of the subject of manpower that there is presentation of the new types of mental health workers called for by the emphasis on community mental health care and also of the persisting and debated possibility of upgrading subprofessional workers.

It might have been more well rounded to have added one chapter with some views of a

psychiatrist not involved with institutions. While most of the authors indicate that the psychiatrist in private practice has little to do with the manpower problem, one might have added his own ideas on careers, education, or use of subprofessions.

In the overlap of ideas in these papers, the outstanding fact seems to be the need to clear up muddy thinking about mental health manpower. In short, this seems to point to the necessity to emphasize subgoals, to clarify careers in individual and disparate employment opportunities in the mental health field, to educate according to specific needs not according to a vague idea of "Manpower for Mental Health."

Mrs. Wilbur F. Pell, Jr.
Chairman
NAMH Program Committee
Shelbyville, Indiana

The General Practitioner's Role in the Treatment of Emotional Illness: Proceedings of a Symposium Held at Boston State Hospital

Edited by Alvin Becker, M.D.

Springfield, Ill., Charles C Thomas, 1968. 101 pp.; \$5.75.

This Volume is Number 5 of the Boston State Hospital Monograph Series and consists of an edited report on the papers presented, with ensuing discussions, at a symposium sponsored by the Massachusetts Chapter of the American Academy of General Practice and the Northern New England District Branch of the American Psychiatric Association. Since it was the purpose of the editor to carry the "flavor" of the conference, there is, not unexpectedly, an unevenness in the quality of the material presented. However, the major presentations ably reflect the views of individuals experienced in the subject matter. In general, there is emphasis on the psychiatrist's recognition of the need for collaboration with other disciplines in medicine, particularly with the general practitioner.

There is the response of the general practitioners indicating at least a theoretical willingness on their part to subject themselves to the tutelage of the psychiatrist while at the same

time posing a cautionary note regarding the need to define more concisely the requirements of the general practitioner with due consideration. To this is added a less than subtle implication that the psychiatrist's own training and experience may provide obstacles to this collaborative effort.

This monograph should be of general interest, particularly in emphasizing the need for additional similar confrontations. The subject matter gains additional pertinence through the recent formation of the American Board of Family Practice, Inc. with its responsibilities of developing educational curricula and certifying training facilities.

Harvey J. Tompkins, M.D.
Director of Psychiatric Services
St. Vincent's Hospital
New York, New York

Poetry Therapy

Edited by Jack J. Leedy

Philadelphia, J. B. Lippincott, 1969. 288 pp.; \$7.00.

Because this compilation of contributions seems to put primary emphasis on the relationship of poetry to group psychotherapy, I am tempted to think an appropriate subtitle might be: *The Poem as a Catalytic Agent*. The essence of the effectiveness of poetry is that it provides a means for the patient to begin talking about himself indirectly, via the poem. He makes personal disclosures he hesitates to make in direct expression, giving them the socially acceptable form he feels so important.

But what of the patient/client who wants to create poetry himself, to go beyond reading and discussing another's words? If he presents to others an artistic creation it may indicate increasing trust in them, and a healthy decrease in fear of criticism or need to be perfect, a desire to bring out what before was taboo as an expression of increasing awareness of self. The editor, J. J. Leedy, defines a poem as "the shortest emotional distance between two points, the points representing the writer and the reader."

Contradictions when compiling the opinions of varied writers are inevitable in a book such as this. One that I particularly noted was the

contrast of opinion concerning what type of writing of poetry is to be encouraged. At one point it is said that the literary and grammatical quality of a poet or patient's work is secondary to the achievement of expression of previously repressed feelings. Yet another author believes that the psychiatric interest in the unconscious reinforces the writing of "bad" poetry by encouraging autistic associations, whereas a teacher is interested in organization of thought and feeling, and logical meaning to a patient's work. However, it has been found that the patient with only literary ambitions, i.e. who is evasive, should be excluded from a therapy group.

Having been both a poet and a patient I found a closing comment the most provocative to someone in my position:

The business of making the unconscious conscious is only part of the treatment; maturation into an integrated person is the goal . . . Whether to continue to encourage communication by poetry is another matter. The patients with severe conflicts may be able to communicate in poetry or poetic speech some of their confusion and anguish which they cannot express directly. But one ought to be prepared to relinquish poetry, however interesting or beautiful it has been, in favor of direct speech when the patient is able.

Miss Rosemary Brant
Gainesville, Florida

Nonprofessionals in the human services

Edited by Charles Grosser, William E. Henry, and James G. Kelly

San Francisco, Calif., Jossey-Bass Inc., 1969.
263 pp.; \$8.50.

Through the collaborative efforts of the National Association for Social Workers and the American Psychological Association, a joint conference on the nonprofessional mental health worker was held in Washington, D.C., in May, '67. This publication highlights the key considerations of the conference.

The goals of the use of nonprofessionals in the provision of human services are reviewed—namely, liberation of the poor from long-term hard core structural unemployment, the rational use of manpower and the improvement of human services. Fourteen in-depth studies which explore the problems and possibilities in

employing the nonprofessional are analyzed and the yet unresolved issues delineated.

While the contributors to the publication are affirmative in answering such questions as can we adapt to the emergence of new alliances and new constituencies created by the nonprofessional, the authors realistically point out the still unresolved issues to which the professionals in the field of mental health and other human services must further address themselves.

Ruth Morse, M.P.H.
New York, New York

Mental Health and Social Policy

By David Mechanic, Ph.D.

Englewood Cliffs, N.J., Prentice-Hall, 1969.
171 pp.; (text) \$5.95, (paperback) \$2.50.

Dr. Mechanic's slim volume provides a useful overview of a field much neglected in the past, and only recently coming into its own. While breaking no new ground, it does give the reader an in-depth view of some of the major conceptual and practical problems arising out of psychiatry's effort to relate itself more meaningfully to current economic, environmental and public policy issues.

The author clearly establishes the fact that these "supra" psychiatric factors impinge upon, enhance or contract psychiatry's capacity as intervenor in the total preventive and therapeutic process. Particularly valuable is his sound emphasis on the need for psychiatry to address itself to the problems of the seriously mentally ill. He also gives considerable weight to the importance of transitional services—hostels, halfway houses, sheltered workshops, aftercare programs—flexibly organized in a coordinated and integrated pattern of services.

Dr. Mechanic skillfully analyzes and dissects the various therapeutic options available to the discriminating mental health practitioner. In so doing he helps to destroy encrusted notions and reaction patterns, and thereby encourages the newer and more creative breed of community mental health workers to "do their thing".

Irving Blumberg
New York, New York

Handbook of Community Mental Health Practice: The San Mateo Experience

Edited by H. Richard Lamb, Don Heath and Joseph F. Downing

San Francisco, Calif., Jossey-Bass Inc., 1969. 483 pp.; \$15.

The ingredients for developing comprehensive community mental health services are clearly stated in this practical and useful handbook. One strong message is that a comprehensive community service program does not just "happen" with the opening of a mental health center. A comprehensive, non-discriminating program such as that described in San Mateo County (Calif.) is the product of several years of

careful planning, interagency coordination, integration, implementation and evaluation of available community mental health services.

Basic program principles have been identified and can be used as guidelines for short-cutting what might otherwise require years of trial and error.

Particularly important is the description of the public mental health service model that combines several treatment service models. Here we see a melding of the private practice model of community psychiatry, the social psychiatric model, psychiatric sociology and the public health model into an effective, functional system of community mental health practices.

D. Douglas Waterstreet, M.P.H.
Long Island, New York

BOOKS RECEIVED

Because of space and time limitations, we cannot review all the books sent to this journal. The listing of such books in this column must be considered acknowledgment of the receipt of the volumes indicated. As space, time and subject matter permit, we will publish full-dress reviews of the more significant books in the areas of interest of our readers.

ADAPTATIONAL PSYCHODYNAMICS: MOTIVATION AND CONTROL. By Sandor Rado, edited by Jean Jameson and Henriette Klein. New York, Science House, 1969. 285 pp.; \$12.50. Based on courses of lectures given by the author from 1945 to 1955, this book applies a biological concept of adaptation to the interpretation of healthy and disordered behavior.

ANGER AND THE ROCKING CHAIR—GESTALT AWARENESS WITH CHILDREN. By Janet Lederman. New York, McGraw-Hill, 1969. 63 pp.; \$4.95. Through pictures and text Miss Lederman illustrates the use of Gestalt methods with "difficult" or "disturbed" children in elementary school.

CONFLICT AND RECONCILIATION: A STUDY IN HUMAN RELATIONS AND SCHIZOPHRENIA. By Helm Stierlin. New York, Science House, 1969. 267 pp.; \$8.95. Dr. Stierlin conceptualizes the mother-child conflict and its relevance to the development of schizophrenia and discusses its resolution through patient-therapist interreaction.

EVOLVING CONCEPTS IN PSYCHIATRY. Edited by Perry C. Talkington and Charles L. Bloss. New York, Grune & Stratton, 1969. 169 pp.; \$9.75. This is a collection of papers presented at a seminar commemorating the fiftieth anniversary of the Timberlawn Psychiatric Center, Dallas, Texas.

HOW PSYCHOTHERAPY HEALS. By Richard D. Chessick. New York, Science House, 1969. 227 pp.; \$9.95. The subtitle of this book is "The Process of Intensive Psychotherapy". Dr. Chessick writes for students, therapists and patients who want to gain maximum benefit from the process.

MENTAL HEALTH BOOK REVIEW INDEX: CUMULATIVE AUTHOR-TITLE INDEX, VOLS. 1-12, 1956-67. Edited by Ilse Bry and Lois Afferbach. New York, Council on Research in Bibliography, 1969. 178 pp.; cloth \$15. Serves primarily as an index to the entries for the 4,000 books and 22,000 reviews listed in the first twelve volumes of the Mental Health Book Review Index.

MENTAL HEALTH BOOK REVIEW INDEX, VOL. 14. New York, Council on Research in Bibliography, Inc., c/o Research Center for Mental Health, New York University, New York, N.Y. 10003, 1969. 92 pp.; \$10. Uses the judgments of the editors, book review editors and reviewers from more than 200 journals as a basis for integrating the monographic literature in the behavioral sciences.

IF TEACHERS WERE FREE. By Richard Renfield. Washington, D.C., Acropolis Books, 1969. 158 pp.; \$4.95. Analysis of what's wrong with our schools and what to do about it.

NEUROPHYSIOLOGICAL AND BEHAVIORAL ASPECTS OF PSYCHOTROPIC DRUGS. Edited by A. G. Karczmar and W. P. Koella. Springfield, Ill., Charles C Thomas, 1969. 199 pp.; \$12.50. Compiled from workshop sessions of the American College of Neuropsychopharmacology, it includes articles by 18 authors.

PSYCHOANALYSIS: RADICAL AND CONSERVATIVE. By Philip Lichtenberg. New York, Springer Publishing Co., 1969. 127 pp.; paperback \$2.95. The author sets himself the task of identifying and sorting out the competing social preconceptions that exist in the body of psychoanalytic theory.

RESIDENTIAL TREATMENT FOR CHILD MENTAL HEALTH: TOWARDS EGO-SOCIAL DEVELOPMENT AND A COMMUNITY-CHILD MODEL. By Gabriel D'Amato. Springfield, Ill., Charles C Thomas, 1969. 186 pp.; \$8. Questions the concept of residential treatment for children and offers alternatives.

A TEACHING PROGRAM IN PSYCHIATRY, VOLS. I & II. Vol. I by Peter G. S. Beckett and Thomas H. Bleakley, Vol. II by Peter G. S. Beckett, Edward F. Domino and Thomas H. Bleakley. Detroit, Mich., Wayne State University Press, 1968. Vol. I, 234 pp.,

Vol. II, 269 pp.; paperback \$3.50 each. Basic handbook for teaching clinical psychiatry.

THEORIES AND METHODS OF GROUP COUNSELING IN THE SCHOOLS. Edited by George M. Gazda. Springfield, Ill., Charles C Thomas, 1969. 220 pp.; \$7.50. Ideas drawn from eight contributors in the field.

THE PSYCHOLOGICAL IMPACT OF SCHOOL EXPERIENCE: A COMPARATIVE STUDY OF NINE-YEAR-OLD CHILDREN IN CONTRASTING SCHOOLS. By Patricia Minuchin, Barbara Biber, Edna Shapiro and Herbert Zimiles. New York, Basic Books, 1969. 521 pp.; \$12.50. A study of fourth-graders in four different urban schools ranging from "traditional" to "modern".

THE INDIVIDUAL, SEX & SOCIETY. Edited by Carlfred B. Broderick and Jessie Bernard. Baltimore, Md., Johns Hopkins Press, 1969. 406 pp.; paperback \$4.50. Prepared by the Sex Information and Education Council for the United States (SIECUS), this book is a good reference for educators and other community planners. In addition to information about teaching about sex it provides helpful information on normal sexual functioning. Other good features include lists of suggested readings and a comprehensive glossary.

Law, Society and Mental Illness

Reprint from the January 1970 issue of MENTAL HYGIENE. \$1. Includes following list:

Community mental health and the criminal justice system, Shah;
Development of community mental health programs in the civil area; Woloshin and Goldberg; Titicut follies revisited: a long range plan for the mentally disordered offender in Massachusetts, McGarry;
New York's mental hygiene law—a preliminary evaluation, Zitrin, Herman and Kumasaka;

Who is competent to make a will?, Weihofen and Usdin;
A radical view of social welfare and mental health, Ginsberg.

Order from NAMH, 10 Columbus Circle, New York, N.Y. 10019

Film Reviews

Page 2 (8 minutes, black and white, released 1969). Made by Andy Plessner and distributed by Youth Film Distribution Center, 4 West 16th Street, New York, New York 10011. Purchase price: \$80; rental fee: \$15 including handling, insurance and shipping one-way.

A teenager's view of life in his affluent Long Island community can be filled with unhappiness, searching and frustration. Seventeen-year old Andy Plessner, has captured these feelings on film. He speaks out on sex, drugs, the generation gap, and the frustration of what most adults would consider an easy, enjoyable adolescence. By means of sophisticated camera techniques, the viewers are taken into the filmmaker's mind and see life as he does. While there, they develop an awkward feeling, like something is "out of joint", not just right. They feel, but never actually are told, what causes this aura of uneasiness—they just know it exists.

Members of the audience empathize with the adolescent as he moves from complete enjoyment of sex to guilt, from group enjoyment of marijuana to loneliness, from the questioning, perplexed gazes of parents to solitude and mental turmoil in a quiet bedroom. After seeing the film, adults are likely to discuss the feelings and emotions experienced by the young man and what caused them; young people will probably discuss the reality Plessner has captured.

This is an excellent film for use with young people in a middle class environment. Since it has been made by a young person, it should elicit a more free-flowing discussion than might be expected from a film on a similar theme, but conceived and produced by those traditionally associated with the making of documentary films. For adult audiences, *Page 2* will provide an authoritative glimpse into the lives and minds of young people today.

Andy Plessner is one of several young filmmakers who have been given the opportunity to express themselves on film through youth film clubs in the New York City area. These clubs are part of the Young Film Makers' Foundation established by Rodger Larson, an art and film teacher interested in the creative potential of young people from all social, economic and ethnic backgrounds. The Youth Film Distribution Center, under the direction of Robert Polin, was set up by the Foundation to distribute the films nationally. More information on the Foundation and a complete listing of

young film-maker films are available from the Distribution Center.

The Seekers (31 minutes, color, 1968). Produced by Myron Solin of Benchmark Films for the New York State Narcotic Addiction Control Commission. Available in New York State on free loan (with a speaker) from New York State Narcotics Addiction Control Commission, Executive Park South, Stuyvesant Plaza, Albany, New York 12203. Others may rent it at \$40 or buy it at \$390 from Benchmark Films, 267 West 25th Street, New York, New York 10001.

The emotional experience of this film is enough to make it worth the viewing. But the message is even more impressive—that "copping out" on drugs merely postpones reality; it does not do away with it. The young people (ages 15 to 25) in this film are members of an encounter group in New York's Greenwich Village—former drug users who are now helping themselves and others to keep off drugs through group therapy. The film's basic message comes from the spontaneous and highly emotional things they say to each other during reality therapy sessions. The viewer is brought to understand the turmoil and frustrations that are real fears in the lives of these young people. Because they all have at one time chosen the drug way out, these young people now have more worries and hang-ups than they did before drugs were a part of their lives. Reality and its problems are still there. But now so are the added fears that accompany prolonged and heavy use of drugs and narcotics.

As a young-person-to-young-person film, this is unique. These youngsters have been through the real lows of drug addiction—but they do not preach; they tell it as they see it, how it is for them now having been through near catastrophe. These youngsters are searching. Before the cameras, they are true "Seekers"—not unlike most young people of today. The only difference is that they have been through an experience they do not wish to repeat—and one they do not want others to try.

PAM WILSON
Mental Health Materials Center
New York, N.Y.

(These reviews are adapted from Information Resources Center Bulletins #159 and #85.)

LETTERS TO THE EDITOR

MENTAL HYGIENE encourages discussion of articles which appear in it. Letters to the Editor should be typed, double-spaced, preferably 150 to 200 words in length. The writer's name, professional affiliation if any and address should appear at the end.

TO THE EDITOR:

As a lawyer, I found the paper by Weihofen and Usdin, "Who is Competent to Make a Will?", in the January 1970 issue of *MENTAL HYGIENE* to be most timely and interesting.

Particularly useful is the succinct statement of the legal requirements to establish testamentary capacity and the ensuing discussion which I believe should equip any practising lawyer to (1) determine to his own satisfaction that his client is competent to make a will and (2) record for future use, if necessary, the statements of the witnesses, the lawyer and other disinterested, non-medical observers, reciting the facts and observations establishing competency.

If I were faced with this problem, I believe I would rely entirely on the above procedure, without calling in a psychiatrist. If, however, my client were in a mental hospital or had any history of mental or serious emotional illness, I would definitely advise examination by a psychiatrist.

I note that the authors do say that the presence of a psychiatrist at the signing of the will might give rise to the argument that those supporting the will were concerned about the testator's mental competency. I suggest that if this claim were advanced it is highly likely that the claim of undue influence would also be made. This being so, I should hesitate to reinforce those claims by having a psychiatrist present unless there were a past history or present confinement.

MICHAEL E. FREELUND
Cedarhurst, New York

TO THE EDITOR:

I found your January issue on *Law, Society and Mental Illness* provocative. Saleem Shah's paper on community mental health and the criminal justice system was superb. I liked particularly his concern with the tendency of mental health professionals to equate behavioral deviancy with mental illness. I would like to hear more about his suggestion to divert certain kinds of offenders away from the criminal system and into "other social institutions." Are

the other institutions able or willing to deal with them? Do we not also have an obligation to improve and to convert the criminal system into something better? Isn't a direct attack needed against the imperfections of the criminal system as well as diversionary tactics?

I was much more provoked, however, with the Woloshin and Goldberg paper. It posed the confrontation of mental health views and legal views on commitment as if these were black and white issues, the mental health people naively advocating "easy commitments" (their words) and the legal people stoutly defending civil rights, "strict commitment procedures" (again their words), due process of law, God, country, and Yale (Law School, of course).

The issues in this field are just not that simple. Cooperation between professions is not built on such antagonistic standards. In large measure, the "strict commitment laws" do more to protect the non-mentally ill who might get caught up in the system than the sick who need treatment and hospitalization. How are we to make effective treatment readily available to the people who need it? This is our challenge.

WILLIAM J. CURRAN, LL.M., S.M. Hyg.
Harvard Medical School

TO THE EDITOR:

Samuel Grob, in *Psychiatric Social Clubs Come of Age* (*MENTAL HYGIENE*, 54:129-136, 1970), has unwittingly omitted mention of the first organization of ex-patients of a psychiatric hospital known as the Wender Welfare League, founded in December 1934. In April 1936 the name was changed to The League for Mental Health, Inc. Regular monthly meetings were held in a midtown hotel and about 150 members (ex-patients) would attend. The League established and operated a thrift shop to rehabilitate ex-patients. In 1944 it established the first evening mental health clinic at the Beth Israel Hospital in New York City. At present it is giving financial support to the New York Clinic for Mental Health, a non-profit organization.

JACOB H. FRIEDMAN, M.D.
Bronx, New York

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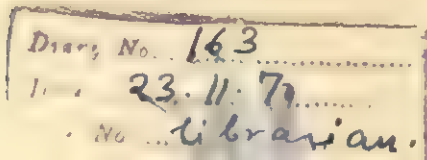
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Joseph D. Matarazzo, Ph.D.

A National Mental Health Manpower Showcase Conference: NAMH Leads the Way

In February 1967 NAMH President Earl Warren, Jr. appointed a Program Committee and, among other responsibilities, charged it to examine the current and projected future shortage in mental health manpower and to make recommendations to guide the Mental Health Association at national, state, and local levels in charting its activities in this area. As one of its first tasks the committee set about defining the present state of knowledge about mental illness as it related to the manpower dilemma and to examine what proportion of this shortage could be alleviated by more recruitment into the four core mental health professions. Position papers prepared by three committee members with broad experience and background knowledge on these issues were published in *MENTAL HYGIENE*.^{1, 2, 3, 6}

Out of this beginning the committee evolved a *Statement on Manpower*, supplemented by specific *Mental Health Manpower Action Guidelines*, which were officially accepted and published by the NAMH Board of Directors as the Association's position regarding the critical mental health manpower shortage and the ways in which state divisions and local chapters could each begin to search for solutions to the manpower shortage in their own community. However, it was clear that although typically unknown outside their own local area, and with little or no communication with one another, a number of local experiments and enterprises designed to alleviate the mental health manpower shortage had been inaugurated throughout the country. Involved in working with the mentally ill and emotionally disabled were whole new cadres of indigenous nonprofessionals; high school and college students; ex-mental hospital patients and Mental Health Association volunteers manning new half-way houses; junior colleges and universities training new levels and types of mental health

Dr. Matarazzo was Chairman of the NAMH Manpower Conference Committee. He is a Professor of Medical Psychology at the University of Oregon Medical School, 3181 S.W. Sam Jackson Park Road, Portland, Ore. 97201.

workers; foster grandparents with challenging, nurturing responsibilities in relation to institutionalized, mentally ill children; psychiatric aides and other existing professionals working in new roles; and a host of other new types of mental health workers. A member of the committee undertook an initial review of these, and her findings also were published in this journal.⁵ Concurrently the committee studied the findings of an epoch-making investigation⁴ of the actual patients in the state hospitals of one of our fifty states and learned that our manpower shortage was intimately tied in to the fact that, although clearly requiring public care, many of the patients in this country's mental hospitals are not mentally ill or, if they are, do not need 24-hour institutional care. Rather, if the resources were available, over fifty percent of the residents of these mental hospitals could be more effectively treated by neighborhood counseling, other outpatient care, foster care, half-way houses, geriatric and other nursing care facilities, and other innovative types of manpower and community approaches..

This restatement of the need, coupled with the isolated and non-coordinated attempts of a number of communities to find their own local manpower solutions, convinced the NAMH Board of Directors that the National Association quite likely would accelerate these local efforts if it focused a spotlight on them. It was thus that the idea for a Mental Health National Showcase Conference was born.

The three-day conference, convened and sponsored by NAMH, with partial financial assistance from the Johnson Foundation, Racine,, Wisc. and Old Dominion Foundation, New York, N. Y., was held at the Marriott Motor Hotel in Washington, D. C. on February 11-13, 1970. Participating were a select group of 300 key leaders, including representatives from: (1) Mental Health Associations throughout the United States; (2) national leaders from the four core professional societies and numerous allied professional societies; (3) leaders from the highest levels of government, private foundations, and national volunteer organizations; and (4) a unique group of pioneers representing 35 nationally innovative programs which it was the privilege of the show case conference to highlight. The paper by Cowne, accompanying this report, describes a few of these programs. Thus, as envisioned by NAMH, the **Mental Health Manpower Showcase Conference** had two objectives, one primary and one secondary.

Its primary purpose was:

- (1) to demonstrate to key national groups, professional societies, and to state and local Mental Health Associations already functioning and innovative programs which illustrate:
 - (a) new uses of *existing* mental health manpower, including vounteers as well as professional workers.
 - (b) new *categories* of mental health manpower.
 - (c) *new* mental health workers (para-professionals) and new uses of volunteers.
 - (d) new *sources* of mental health manpower, including the disadvantaged and handicapped;

- (2) to stimulate expansion of these new uses of human resources (both staff and volunteers); and
- (3) to alert and demonstrate to Mental Health Associations their potential leadership role in dealing with health manpower shortages at the state and local level.

It was also envisioned that through the process of bringing together those public, private and professional authorities who must assume the necessary leadership to do something about the mental health manpower needs, the following secondary purpose (and its attendant benefits) would be realized:

- (1) to communicate with and to help the traditional professions to recognize their own need to adjust to the influx of new people, positions and disciplines, so that their members welcome assistance where it is assistance that is needed, and are willing to provide guidance and support where this is the indication;
- (2) to demonstrate the responsibility of the traditional professions in:
 - (a) the recruitment, training, placement and professional growth of the new mental health workers, and
 - (b) the recruitment, training and placement of the volunteer who will be functioning in many instances similar to (and in some cases perhaps superior to) the new mental health workers;
- (3) to demonstrate to colleges and universities, selected professional organizations (AMA, both APAs, NASW, ANA, etc.) the kinds of new training opportunities which need to be offered to expand their present important efforts, including the development of pilot manpower training programs; and
- (4) to identify where state and local Mental Health Associations have a responsibility for joining the efforts of the traditional professionals and seeing that enthusiasm and understanding as well as effectiveness, are carried at a high level of performance in order to insure the volunteers an exciting challenge.

Built into the plan for the Conference initially was the appointment of a **National Follow-Up Task Force** charged with the responsibility of reviewing the findings of the Conference and working toward the development of standards of recruitment, training and uniform certification requirements, as well as developing an operational research program aimed at evaluation of the human effectiveness and costs of these programs. Also built into the Conference plan was the stipulation that each State Mental Health Association appoint a convenor who, in addition to attending the conference, would be responsible for convening state committees (with lay and professional members) to review findings of the conference, to consider how these innovative programs can be applied to their specific situations, and to plan in each state an action follow-up conference of appropriate state and local groups to evolve a plan for specific follow-up action to work on those aspects of the mental health manpower shortage, and its solu-

tions, appropriate to its own interests and resources. Mrs. Wilbur F. Pell, 1969 Program Committee Chairman, held a special briefing session for state Association convenors to discuss follow-up activities. She has also been asked by NAMH President James E. Chapman to serve as Chairman of a Manpower Committee that will, as one of its responsibilities, provide consultation and assistance to state Mental Health Associations concerning their follow-up plans. Under the auspices of NAMH, a **National Follow-Up Task Force** has been formed with Dr. Darryl Mase, Dean, College of Allied Health Professions, University of Florida, Gainesville as its chairman. His task force committee members include professional and lay leaders from NAMH, HEW, The Department of Labor, the core and allied mental health professions, and representatives of related groups and constituencies.

The task force met before and during the three-day showcase conference and has had one meeting since. It is clear to each of the many of us who have been working on this problem during the past three years that NAMH's showcase conference was but an opening salvo to the all important work which is just now beginning at the state and local levels.

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Leslie J. Cowne, Ed.D.

Case Studies of Volunteer Programs in Mental Health

Eighteen examples of mental health programs that utilize volunteers are presented. Funding, administrative set-up and difficulties of each program are examined.

A critical need for health manpower exists in many communities. Our population is increasing more rapidly than our mental health training resources, and it is highly unlikely that professional and institutional education will be able to narrow the gap within the next ten years. Volunteers can be an important part of the total effort, very often providing far more than traditional professionals expect of them. Under professional supervision, well trained and carefully selected volunteers can assume major responsibilities for persons in distress. This source of manpower is still not being tapped fully.

In my survey of new approaches to mental health manpower problems last year, I obtained data on some 600 programs, including 200 programs using volunteers in the mental health field. Of these volunteer programs, six were selected for panel presentation at a Mental Health Manpower Showcase Conference in Washing-

ton, D.C. in February 1970, and a further twelve programs were presented in roundtable discussions. These programs show how the educated volunteer can function in a variety of settings at a level comparable with professionally trained persons.

The Community Friend Project of the California Association for Mental Health provides someone in the community, either before the patient leaves the hospital or immediately upon arrival in the community, to establish a continuing, encouraging relationship during the first three crucial months of readjustment to community life. Making a successful adjustment to living outside the hospital demands of a person some of the very resources, strengths and initiative that have been reduced or crippled by his sojourn in the hospital—and requires these resources at a time when he may be least able to call on them. A volunteer can function in this role because he is not a social worker or some other professional with a heavy case load. He is working with only one patient. The volunteer is also seen differently by the ex-patient as compared to the paid worker.

The training program for the Com-

Dr. Cowne served as a full-time volunteer with the National Association for Mental Health while she was on a sabbatical from Brooklyn College where she teaches.

munity Friend project was worked out during a year-long pilot project. Changes were made as needed. Training now takes place in five or six sessions before the Community Friend begins his job and he continues under ongoing supervision, both individually and in a group, with other Community Friends.

The Community Friend is supervised by a Mental Health Association supervisor regarding specific questions about the convalescent relationship and the program. Some of the volunteer supervisors are retired social workers, or others with supervisory experience in volunteer services. One of the most critical parts of the program is liaison with the hospital and constant contact with agency personnel at the administrative level.

Since 1968, when the program was started, 50 persons have been trained and used. There is opportunity for Community Friends to become supervisors, trainers, or to take part in other aspects of the administration of the project. However, many prefer to remain in the one-to-one, time-limited relationship of being a Community Friend.

The Mental Health Association experienced no real problem in establishing this service except for professional unfamiliarity with the "new" program, which is to be expected despite continued publicizing of it, and changes in the after-care procedures resulting from California's new mental health legislation which became effective in July 1969 and made acceptance of the program slow at first. Occasionally, problems have arisen when the carefully designed initial guidelines were not followed correctly.

Evaluation of this program is being carried out under the supervision of the Director of Research of one of the state mental hospitals. The four major demonstration

programs will continue through June 1970. At that time, revised guidelines will be worked out to enable other Mental Health Association Chapters to undertake the Community Friend projects.

The Mental Health Case Aide Program at the Metropolitan State Hospital in Massachusetts started in 1964 and involved volunteers working under the supervision of social workers in the hospital. It is sponsored by the Mystic Valley Mental Health Association. The Case Aides chosen are mature, selected women volunteers who commit themselves to a minimum of one morning a week working on a one-to-one basis with chronic hospitalized mental patients to aid their re-socialization and, hopefully, their return to life outside the hospital. The social workers select and match patients to Case Aide volunteers.

There is no training prior to the Case Aide's meeting with her patient for the first time. However, there is continuous on-the-job supervision provided by the social workers during the group sessions which are held weekly after the Case Aides have spent time with their patients. The Case Aides meet in groups of 12 with their social worker for lectures, and sessions with other mental health professionals to discuss the progress they are making with their patients and the problems they are encountering. After each weekly meeting with the patient, the Aide writes a detailed report of activities, the topics discussed, and personal reactions. The Aide and the social worker evaluate these reports together in monthly conferences.

Since the inception of the program, 143 Case Aides have been involved; each for a minimum of one year, many for two or more years, and several for four to five years. Several Case Aides have gone on to graduate studies in the health professions

and many have taken full-time paid work in the field.

There were no significant obstacles in establishing the program. The hospital staff had been skeptical at the beginning, but was prepared to go along and see how it would work out. Since each step was carefully studied and planned in advance, the professional personnel of the hospital have become convinced that the program is an asset.

No formal evaluation procedures have been applied. The criteria for success were simply the number of patients worked with, compared with the number who have been able to leave the hospital and function satisfactorily in the outside world, and the feedback from the volunteers of their feelings concerning the value of the program to them and the incomparable experience that it offers. Because of the success of this program, it is expected that the State Department of Mental Health will provide some budget to the hospital so that this can become a permanent part of the hospital planning for the patients. The Case Aide Committee which now administers the program will then continue to operate in an advisory and supportive capacity to the social worker staff of the program.

The Home Training Program for young mentally ill children on the waiting list of the League School for Seriously Disturbed Children in Brooklyn, New York, involves the paid professional staff of the school, who work directly with the parents of the young mentally ill children. The parents function as volunteers. These "volunteers" observe the weekly demonstration teaching sessions of their own child and his specially trained teacher and thus learn effective methods of child rearing and behavior management which they are able to make use of on a day-to-day basis in their own homes. To help them clarify

and generalize what they see, the parents also have weekly meetings in small groups with the director and the social worker. These discussions are developmentally oriented and attention is focused on self-help skills, socialization, speech and language stimulation, and pre-academic skills.

The number of programs for very young, very sick children is insufficient for the demands now generated and this program was initiated to provide services for such children on the waiting list for admission to the school. Frequently, children as sick as the ones currently served in this program, are excluded from programs designed for the mentally ill young. The only requirement for entry into the program is that the parents need these services, and that they agree to bring themselves and their child at the appointed times.

Since 1966, when the program was started, this service has been made available to more than 100 families. The success of this program can be gauged by the ability of these parents to function more effectively, not only with their difficult sick children, but with their healthy children as well. In many cases, it has freed the parents to the degree that they have been able to get jobs or return to courses of study.

This program has been funded by both the school, National Institute of Mental Health, and the New York City Community Mental Health Board. Evaluation was built into the design of the project. The children of both the control and experimental groups received thorough pre- and post-evaluation on a number of measures. As a result of exposure to this program, the improvements in the experimental group were significantly greater than the improvements made by the control group. Parents also reported increased self-assurance in handling their children.

Initially, there was considerable skepticism about the possible effectiveness of such short term intervention. However, because of its success, the program will be continued as an integral part of League School Community Service. It will also serve as the model for other similar programs.

The Community Lodge Treatment Program for Mental Patients—Michigan. Since its inception as an experimental project on the West Coast in 1963, this program has been imitated and implemented in other parts of the country. Research revealed that post-hospital adjustment of patients who remained out of the hospital longest was best for those who were employed and who had a socially supportive living situation within the community. Post-hospital adjustment was unrelated to hospital behavior, but was highly related to the post-hospital social situation in which the patient found himself.

The object of a community lodge society is to create a productive and supportive work-living situation and to provide a total community social sub-system for the rehabilitation of the patients. The three basic goals are to provide members with social support from the group of former patients who live with them, to create a feeling of responsibility among the members of the group for each other's welfare, and to develop a social situation which will promote autonomous decision-making on the part of each member. The essential characteristic of a "lodge" is that there are no "live-in" staff; only lodge staff that are on call. That is, only lodge staff members contact the hospital when the need arises; only technical skills or knowledge, where these are lacking within the lodge members, are requested from outside. An important criterion for selecting the patients for a community lodge program is that the therapeutic need of the long-term patients be

The only obstacle to the acceptance of this program has been where professionals have not had experience working with volunteers.

balanced with the need to establish a desirable group composition. Thus, the selection of the lodge members is based on the patient's inability to live in the community without a socially supportive situation, and his inability to work in the competitive labor force. Members must have differing degrees of maladjustment. While some may have gross psychotic symptoms, others should be relatively symptom free. This allows leaders to rise from the less handicapped who can take charge of the group.

All members must be given a part in the lodge operation, with concomitant responsibilities and with attainable behavioral expectations (although some latitude is allowed for mild deviance from these expectations). There must be a feeling of group cohesiveness, and there must be free entry into, and exit from, the lodge without penalty.

Funding has been provided through federal, state and hospital monies. Community lodges are usually established after sufficient funds have been obtained to purchase a house in a section of town which will be accessible to both the hospital and the community which the lodge members will serve.

The obstacles to establishing such a program are usually financing, choice of location, selection of patients, and the selection of staff. The major problem among these is the selection of "staff" because of the change in roles demanded, i.e., from being a dependent hospital patient, to a directing, self-supporting, supervising and group-supporting person.

Future plans call for the expansion of this program so that the lodge will no longer be a "sheltered living-working facility", but rather an alternative community mental health care system, where the residents of the self-governing lodge would participate in making plans to provide each person with a social situation, within the lodge sub-system, which would allow him the maximum possible arena for personal and social adjustment on a flexible basis. Patients can then also be drawn from a Community Mental Health Center population as well as the hospital population.

The Volunteer Services of the Salt Lake County Comprehensive Mental Health Center in Salt Lake City, Utah. This program was started in 1961 and volunteers are used as case aides for individual patients, aides in therapy groups, leaders and/or aides in activity groups, and in a variety of miscellaneous roles that are expected of them connected with fund-raising, public relations, office or administrative tasks. The volunteers are used in out-patient services, hospital services, crisis intervention, children's services, juvenile court, and research and evaluation.

Volunteers are carefully selected with regard to their individual capacity and functioning, specific talents and interests, capacity to relate, appropriateness of affect, and responses to anxiety-provoking situations. The coordinator of volunteer services makes the specific assignments of the volunteer to the place or person that needs help. Individual orientation and screening provide the initial training, then continuous ongoing training, are available under staff supervision. For example, in the Partial Hospitalization Unit, volunteer aides are always welcome at the daily 4 p.m. meeting of that unit, but the focus is on maintaining the spontaneity of the

volunteer, and effort is made to ensure that they not act as "junior therapists".

Funding for the salaries for the professional staff is met by some county, state and federal funds and additional fund-raising through local volunteer activities.

The only obstacle to the acceptance of this program has been where professionals have not had experience working with volunteers. However, once a successful experience has been completed, subsequent acceptance of such volunteers has been easy. Occasionally, patients are reluctant to accept the help from volunteer case aides, but this resistance can be minimized with the assistance of the professional persons in contact with the patient.

S.E.R.V.E. (Serve and Enrich Retirement by Volunteer Experience) is a demonstration project for older volunteers in community service. Its aims are: to meet the increasing need for service volunteers in social, welfare, health, educational and cultural agencies in the community; to provide a satisfactory and meaningful role for retired persons; to help the older person maintain his feeling of worth and usefulness; and to broaden his scope of interest. The volunteers serve on one chosen day of the week in one selected agency.

Continuous in-service training is given through regular group meetings with directors of agencies and SERVE staff. During the past three years 560 volunteers were placed and trained, with 420 of these older volunteers still giving active service. Many volunteers have accepted more demanding responsibilities after entering their area of service.

The project has been funded through the combined efforts of: Health, Education & Welfare, matching funds provided by Community Service Society, and private foundations and individuals. Some initial unwillingness to accept volunteers in

agencies was experienced, but that resistance has been eliminated with successful work from the volunteers.

Volunteer Case Aide Program of Canton, Ohio. This program was based on the premise that some of the problems of human need can be solved by intelligent use of volunteers to extend and give depth to the services of the professional in the field of health and welfare. After a screening process and 20 hours of training, volunteers are placed in a cooperating agency, where they are trained to work as part of a team. Placements have been made in Juvenile Court, city schools, the Community Mental Health Center, County

The major cause of losing Bluebellies is when staff people in nursing homes or hospitals think they can "shove off" their work on Bluebellies.

Welfare Department, City Government Urban Renewal and Family Service Society.

This program has been funded jointly by United Fund and Junior League. The only obstacles to acceptance so far have been some unwillingness by professionals to supervise and use the volunteer effectively. The effectiveness of the volunteer and her satisfaction depend to a large extent on the attitudes of the professional staff.

Bluebellies of the Wichita Mental Health Association are teenage girls who serve senior citizens in nursing homes and the mentally ill in the Wichita Falls State Hospital. The girls have a choice of location and time but must give at least two hours of service a week. Their specific duties supplement the professional staff and fill obvious voids in the lives of the patients, but they may not be used as replacements for nursing staff, or maid ser-

vice. A ten-hour training course is given and monthly reports of service given by Bluebellies are sent from the agencies where they are assigned. There is an award system for the number of hours given in service. The program is funded entirely by the monies the girls earn and they have a fund raising project to earn scholarship money for those girls who cannot pay the yearly dues. The major cause of losing Bluebellies is when staff people in nursing homes or hospitals think they can "shove off" their work on Bluebellies. There must be a close working relationship between the adult volunteers administering and supervising the program.

Big Sisters of Racine, Wisconsin. These women from all walks of life are volunteering their time and friendship to a young girl in need of better peer and adult relationships. After an orientation period the volunteers are screened and matched with the young girls according to interests and congeniality.

Funding is a community effort supported by dues, and gifts from individuals and organizations. There were few obstacles to establishing this program. Most institutions were very anxious for it to get underway.

The Student Volunteer Program of Marion County Association for Mental Health in Indianapolis was started to stimulate interest in mental health careers, educate the high school youth through the development of projects, and to provide service to the community. Primary emphasis has been devoted to service in state hospitals. The students use their special talents in; occupational and recreational therapy, children's and nursing services, escort service, care and comfort of infirm patients, and service in the maintenance programs. At the beginning there was some resistance on the part of the hospital

staff to using high school volunteers, but this has been overcome with successful experiences.

Behavioral Analyst Training Program of Southern Arizona Mental Health Center. This program, which began in 1965, trains both paid workers and volunteers in the use of behavior modification techniques in the child's natural environment. It was started as a demonstration project with pre-delinquents and now extends to the treatment of a wide variety of behavioral disorders. In working with maladaptive behaviors the environment is altered so as to prevent rewarding misbehaviors and systematically reward increased approximations of desired behaviors. In addition, the analysts train parents and others to be agents of change.

Training, designed to teach specific skills necessary to perform the duties of a behavioral analyst, is conducted by staff at the Center. Formal training lasts six weeks, but continues with close supervision and in-service training. The program is funded by the State of Arizona. There was some initial reluctance on the part of many professionals to accept this new program, but as effectiveness has been demonstrated this resistance has been dissipated.

SWAP: Social Worker Aide Program utilizes volunteers to assist the school social workers in Portland Public Schools, Oregon. It was initiated in Jan. '68 to alleviate the results of a cutback on taxes which reduced the number of social workers from 31 to 12. Many volunteers are former teachers and social workers, and mothers whose children no longer need them full-time at home. Volunteers are interviewed by the supervisor of the School Social Workers and then scheduled for an afternoon work session. Additional training is given to each volunteer as she works. These Aides perform many time-consuming tasks

that were formerly done by the social workers and so allow the social workers more time to work with those needing help. As soon as the Aides learn new tasks, they are allowed to assume new responsibilities, and many ex-volunteers have gone on to gain advanced training in social work. This program is sponsored by the Mental Health Association of Oregon and Special Services Department Portland Public Schools, Oregon. It is funded by The Jackson Foundation and additional private monies. This service has been accepted by all concerned and has been recently incorporated into the VIPS Program (Volunteers in Portland Schools). Thus many more volunteers will be trained by the school Social Work Department. There are now 300 in the entire program compared to the 12 trained in the first year.

A Training Program for New Professionals, Paraprofessionals and Volunteers is sponsored by the Young Adult Institute & Workshop, Inc. in New York. It provides in-service training at the Institute for college trainees and interns, community volunteers and Urban Corps Workers, but only the Urban Corps Workers receive a salary provided for under the Federal Work Study Program. This program began in 1964, and thus far, 175 persons have participated. It was initiated to answer the local college pleas for field training experience for students. The Institute realized that such a program would provide more intensive work with its mentally handicapped clients and would also tap the reservoir of capable community volunteers. The community volunteers and paraprofessionals are screened and many paraprofessionals participating have had at least a year's training. Each trainee is assigned to an appropriate segment of the Institute's Adjustment Center Program according to his interests and the amount of time he can

work. Under supervision, the trainees assist the group workers in involving the clients in the programmed recreational activities. Often, a trainee is assigned his own group or certain individuals for participation in specific activities. In the future, the Institute plans to set up a cooperative training program for paraprofessionals.

Foster Grandparent Program not only provides elderly adults with employment, but it enables institutionalized, hospitalized or dependent neglected children to experience a warm relationship with a mature adult who cares. This program began in May 1967, and is sponsored and funded by the Administration on Aging, of the Department of Health, Education and Welfare. The program provides a social service to adults 60 years of age or older, in that it gives them a meaningful and socially acceptable role in their mature years. Acceptance in this program requires the elderly men and women to be able to read and write, and more important, the candidates must have a warmth and understanding for children. Candidates participate in a 40-hour orientation. The first 20 hours include introductions, discussions and workshops dealing with children and their needs. The next 20 hours are spent at the host institution where the Foster Grandparent is assigned. Here he is briefed on procedures, purposes and goals of his assignment, and given in-service training. This program is to be expanded, and to insure this expansion, a Foster Grandparent program is to be incorporated into every Model Cities Day Care proposal.

The Social Club, Birmingham, Alabama was established to provide convalescing mental hospital patients with a pleasant place to make friends, an opportunity for assuming responsibility, a sense of belonging, some social rehabilitation, and a place

where they could find something interesting to do.

Potential members are contacted through physicians, nurses, hospital personnel and the Mental Health Association. The club rooms are open six hours a day, five days a week.

Volunteers must be over 17 years of age and have an ability to relate constructively to members. They are recruited through churches, civic organizations, colleges, hospitals and the news media. In-service training is provided by the Social Club Director.

The program has been funded by the state through Vocational Rehabilitation and Community Chest. Major obstacles so far have been to obtain adequate funding, and the reluctance of some potential members to take the initial step of coming to the club.

Community Aides Program in Minneapolis was initiated as a result of a request made by the training Director of Pilot City Regional Center, which is a multiple funded agency that provides a variety of services for the city. The request was for background and training for untrained non-professional aides who are engaged in direct service in the community. The program, sponsored by Pilot City and the Minnesota Association for Mental Health, began operating in November 1969. It includes a two-hour weekly session, where a speaker makes a presentation and a discussion follows. These sessions are designed to provide the Aide with some insight into the problems they will face in the community. The Minnesota Association for Mental Health provided the funds for the initial work. Some of the Aides trained are on the payroll of the Pilot City Regional Center. Some professionals felt that they were being asked to help too often, but this is the only difficulty so far.

These eighteen volunteer programs which were presented during the conference, demonstrated conclusively that the manpower problem in the mental health field can be alleviated in some measure by such activities. It is hoped that other agencies and professional organizations will undertake further expansion of these programs in their own areas while waiting for the professionals and ancillary support personnel to be trained in the traditional fields.

Southern California Counselling Center, Los Angeles was founded as a community service for those who need mental health counselling but cannot afford it. Professional staff assume responsibility for screening counsellor applicants and training and supervising them in their subsequent work assignments, which include individual, family, and group counselling. The criteria used for selecting these "housewife counsellors" are: life experience, academic background less than advanced degree; personal therapy; sensitivity; empathy; non-possessive warmth; genuineness; detached-involvement; flexibility and a sense of proportion.

Counsellors commit themselves to one or two nights of counselling clients. They confer weekly with supervisors, and attend monthly weekend workshops as well as irregularly scheduled workshops. The two-year training program at the Center can be used to meet some state pre-requisites for licensing.

The Agency is a walk-in center. No limit is set on the number of appointments. No fee is required if the applicant cannot pay. The Center is non-sectarian. There is a 24-hour telephone service for referrals of emergencies to available counsellors.

The Center is funded by private contributions; original funding for basic operations was the major obstacle. Volunteers are self-referred. No recruiting is undertaken.

PROGRAMS LISTED

Student Mental Health Assistant
Mrs. Raymond Von Spreckelsen, Hospital Services
Director

Mental Health Association in Marion County
615 N. Alabama Street
Indianapolis, Indiana 46204

Behavioral Analyst Training Program
Dr. Rachel Burkholder, Staff Psychologist
Southern Arizona Mental Health Center
1930 East 6th Street
Tucson, Arizona 85716

SWAP (Social Work Aide Program)
Mrs. Langdon Hedrick, School Social Worker Aide
SWAP
35 S. W. 88th Street
Portland, Oregon 97225

Training Program for New Professionals, Paraprofessionals and Volunteers
Young Adult Institute & Workshop, Inc.
Mr. Thomas Robert Ames, Executive Director
260 Park Avenue, South
New York, New York 10010

Foster Grandparents
Miss Anne Johnson, Director
Chicago Commission for Senior Citizens
203 North Wabash Avenue
Room 2000
Chicago, Illinois 60601

Social Club
Mrs. Nancy Fritz, Director of Day Activities
Jefferson County Association for Mental Health
3600 8th Avenue, South
Birmingham, Alabama 35222

Social Work Assistants
Mrs. Jean Carmel, Executive Director
Wellmet Project, Inc.
6 Newport Road
Cambridge, Massachusetts

Community Aides
Mr. Arthur L. Cunningham, Board of Directors
Minnesota Association for Mental Health, Inc.
45-10 West 77th Street
Minneapolis, Minnesota 55435

Community Friends Project
Mrs. Marvin T. Smith, Chairman
California Association for Mental Health
901 "H" Street, Suite 212
Sacramento, California 95814

Mental Health Case Aide Program
Mystic Valley Mental Health Association
186 Bedford Street
Lexington, Massachusetts 02173

Home Training Program for Young Mentally Ill Children

Mrs. Nanette Doernberg, M.A., Program Director
League School for Seriously Disturbed Children
567 Kingston Avenue
Brooklyn, N. Y.

A Community Lodge Treatment Program for Ex-Mental Patients

Dr. David H. Sanders
Associate Professor of Psychiatry & Psychology
Michigan State University
East Lansing, Michigan

Volunteer Member of the Treatment Team
Mrs. Joanne Smith & Mrs. Orla Shaw, Directors
Salt Lake County Comprehensive Mental Health Center
156 Westminster Avenue
Salt Lake City, Utah 84117

S. E. R. V. E. (Serve & Enrich Retirement by Volunteer Experience)

Mrs. Janet Sainer—Staff Specialist
Community Service Society of New York
105 East 22nd Street
New York, New York 10010

Volunteer Case Aide Program
Mrs. Margaret Kirkpatrick, Executive Director
United Fund of Central Stark County
618 2nd Street, N.W.
Canton, Ohio 44703

Bluebelle Teenage Volunteers
Mrs. Patricia Looney, Executive Director
Wichita Mental Health Association
1511 D. Beverley Drive
Wichita Falls, Texas 76309

Big Sisters of Greater Racine, Inc.
Mrs. Ernest L. Macvicar, President
Big Sisters of Greater Racine, Inc.
6427 East Hoods Creek Lane
Franksville, Wisconsin 53126

Southern California Counselling Center
Benjamin Weininger, M.D. & Hans Hoffman,
Administrator
1022 South La Cienega Boulevard
Los Angeles, California 90035

Alanson F. Willcox, A.C.S.W.

The New Professionals

Practical Aspects of the Use of New Careerists in Public Service Agencies

The author discusses planning for use of New Careerists and implementation of such a program. Common pitfalls, such as inappropriate expectations, inability to focus on priorities, and lack of adequate supervision are examined. The New Careers Program, a revolutionary concept, can live up to its promise if it is administered properly.

Introduction

New Careers is one of the more exciting innovations in the field of manpower development, and yet there is a regrettable lack of published material that deals specifically with planning and implementing a New Careers program. The following suggests some guidelines for planning a New Careers program.

The author's experience with several programs using New Careerists has shown that these staff are pressed to serve in a wide "information and referral" capacity for many public service agencies, beyond the specific services of the host agency. While mental health was our initial orientation, we found the programs quickly moving toward a wider, "social health" goal. Indeed, any specialized service outreach program using New Careerists soon begins to experience pressures to generalize its service. Clients will want help in all areas of their

lives, once they have found a person "in tune with" their particular needs, preferences, and style of life. These pressures to "generalize" come from both staff and clients alike.

New Careerists are particularly useful in work with low-income communities. In these areas, one finds people distressed by a conglomeration of emotional, economic, educational, medical, and even political problems. This is not to suggest that such problems exist only in ghettos, but that there is a higher prevalence of "multi-problems" in poverty areas. The poor are also known to be non-users or under-users of traditional public services, due to their apparent lack of motivation or sophistication, and due to the organizational system itself. Factors such as waiting lists, harassed receptionists, and bureaucratic red tape can effectively discourage needy clients from reaching a service professional. Ethnic and cultural misperceptions (on the part of both professional and client) can also interfere in the actual helping process.^{1, 2}

The New Careerist opens up new channels of communication between the agency

Mr. Willcox is Regional Training Coordinator, Region III, for the County of San Mateo Department of Public Health and Welfare, Mental Health Services Division, 220 W. 20th Ave., San Mateo, Calif. 94402.

and the low-income community, and the results will not just be improved communication and service to the consumers. The professional agency will be confronted with more and more of the poverty community's

Thus, a New Careerist who began on his job as a high school drop-out, after several years might find himself working toward a post-graduate degree in teaching or social work.

problems, service needs, and demands. The responsibility to respond to this information is implicit in the commitment to work in the low-income neighborhood.

An additional and essential aspect of the New Careers' rationale is career development. Each job must have built into it a sequence of advancement steps, a career ladder. In this way a low-income person will have open to him a gradual but secure pathway to a lifelong profession, rather than a dead-end job with no future. While a New Careerist is working his way up the job ladder, he is also expanding his educational background. He is attending school, plus gaining academic credit for the job training and experience which he is accumulating. Thus a New Careerist who began on his job as a high school drop-out, after several years might find himself working toward a post-graduate degree in teaching or social work.

To anticipate problem areas, and to plan constructively, one really needs to observe a program in operation. This is the format for the remainder of this presentation. The author's mental health orientation may bias this presentation, but I have endeavored to direct the discussion toward any service. I am chiefly concerned with a program attempting to reach low-income and/or minority consumer groups.

Planning

The first and most crucial developmental phase, as is true in any other innovative operation, is that of planning. To begin with, the agency should look inside its own organization and examine carefully its goals, commitments, and constraints. Some vital questions are: Does the agency have a mandate to serve one or more low-income communities? If so, are the current service-delivery techniques adequate to meet the needs there? (i.e., Is there a demand from the consumer population for more professional services?) Or, as is more common, are the professional services not being used? Is the agency seeking different techniques of service delivery, in hopes of better serving these low-income areas? How high a priority would this program have? Does the agency feel bound to commit a significant portion of its resources to working with the poor? Even though professionally unfashionable, uneconomical (from the standpoint of lucrative Federal grants), or inhumane, a community's service priorities may suggest against investing in New Careers to work with low-income clients.

The agency should be prepared to deal with the kind of explosive social problems which the New Careerist may uncover. A program offering specialized assistance without an active concern for (and some ability to help with) different and more general problems which may be more pressing to the consumer group, will be handicapped even before it starts. Issues such as inadequate welfare grants or scarcity of public housing may appear. A positive response may mean public support for liberalized welfare legislation or for a low-income housing referendum. The political realities of the community must enter into an agency's decision about using New Careerists, from the standpoint of the agency's

own sources of support. Can the agency afford publicly to support this kind of cause?

Community planning is a very important component of a New Careers program. The agency itself must undergo careful scrutiny, and the "target community" should be similarly assessed. It is obviously difficult to arrive at any real picture of the needs of a particular area, without using local people as resources. Community representation is crucial in planning a New Careers program, even more so than for any other service program without this innovation. There are several reasons why this is so important. Community involvement in the planning of a program that is to have a low-income constituency will result in greater support and commitment from the community, as Kellam and Schiff found in Woodlawn.³ They also found that using community people in the planning process brought in valuable information. One of the major demands from the militant minority group spokesman is local participation in decision-making that affects their destinies. If one hopes to work with minority groups, one should, if at all possible, heed their demands. The sooner the low-income community can become involved in planning a New Careers venture, the easier will be the road ahead.

Community involvement does not mean community control. In the author's opinion, low-income people will not benefit from complete control of the New Careers program. This inevitably will isolate the program from the wider community, and from potential sources of support which may be crucial later on. It is far more dangerous, however, to form an advisory group of middle-class community leaders, and then to involve a few target area representatives mainly as a token gesture after the important decisions have been made. The

task is to create an advisory group that represents both the low-income and the wider middle-class communities, and equal numbers from each group would obviously be one way to balance the group.

It will also be hard to find vocal residents who are willing and able to represent their low-income neighborhoods. It will take time and patience to build up trust, but the long-range payoff will be well worth the effort. To facilitate the process, reimbursement could be offered members of the planning group, to help with transportation, and babysitting, or other expenses.

Once the community representatives are reasonably sure that the professionals want to hear about the community the way it really is, and the professionals are equally sure that the community people are not trying to disrupt or to destroy the whole program, then the planning group can begin to function. The group should begin by setting up priorities, assessing which groups in the community most need the agency's attention.

If one hopes to work with minority groups, one should, if at all possible, heed their demands.

The initial definitions of roles and responsibilities for the New Careerists should evolve in this planning group. The planners may need some introduction to the New Careers philosophy, and to some New Careers programs. This group should then make the final decision about the use of New Careerists. If the high-priority problems could best be met by the use of well-trained nonprofessional staff indigenous to the target area, then New Careers may be the answer. If the consensus is that more professional practitioners are needed, then New Careerists cannot fill the bill.

With this in mind, the reader is referred to Appendix I, a hypothetical job description for a mental health New Careerist. Working under such a job description, a New Careerist might visit homes at the request of a welfare worker, clergyman, or others, even neighbors. While explicitly talking about a discussion group program at a nearby neighborhood center or neighbor's home, the worker might also welcome information on the family's use of community services, their need (and eligibility) for other programs, and particular concerns which their neighbors might be able to help them work on. To demonstrate the worker's concern, he might drive the family to the hospital or welfare office, baby-sit during the appointment, or even participate in the conference as an advocate for the client's rights.

Career development is another issue which may need attention from the planning group. The task of drawing up progressively more demanding job descriptions may be handled by the professional staff, but the planning group must decide on the eventual goals. For example, will the New Careers program develop new avenues into established, i.e. "old" careers, or will a whole new profession result? If the former course reflects the planners' decision, then the career ladders should result in post-graduate training in education, social work, medicine, etc. If the group favors the second and more revolutionary approach, then thought needs to be directed at devising an educational and employment system that can create sufficient status and pay to the new profession that results. If there is a focus on strengthening neighborhoods and teaching constructive social action, one might consider the workers as community development specialists. With a B.A. degree in social psychology, perhaps, and graduate training in both city planning and

social work, the New Careerists might prove themselves so useful to inner city and rural poverty communities that their profession would gain official and societal sanction.

It should be readily apparent that planning for a New Careers program is a tremendously complex process, involving many related issues. Planning staff must have sufficient time released from day-to-day duties, so that these issues can be studied and resolved, both inside the agency and in the wider community.

Program

A. Recruitment: The first task facing a New Careers operation, once planning has been completed, is that of recruitment and selection of staff. For recruiting there are several advertising media available, to which should be submitted a brief resumé of the program and the job description for the New Careerist. Other recruitment resources are the various community service agencies, particularly the employment and public welfare offices.

Besides anticipating a great number of applicants, it might help to be prepared for a certain amount of paranoia on the part of a few applicants. Some people interested in the job may have had some unpleasant experience in neighborhood politics and feel that they have to attack or to accuse in order to get a fair hearing. There may also be those applicants whose experience with community agencies has been sufficiently degrading or unpleasant that they anticipate rejection and failure, and they may feel that they have to attack first, to save face.

B. Selection Criteria: There may be organizational and Civil Service criteria that first must be met, such as target area residence, a basic educational level, and the like. There may be requirements basic to the job, such as multi-lingual fluency, and

One might even grant a candidate credit for past psychiatric treatment as "relevant prior experience".

owning and being able to use a car on the job (with adequate insurance coverage and a valid driver's license). Should a New Careers program have an outreach goal, New Careerists should probably have to work outside an office, making door-to-door surveys or visiting specific referrals. With this in mind, the need to establish what might be called "instant rapport" should be explicitly included as a desirable characteristic. This is more than the trite expectation of being able to "present a pleasing appearance." It relates to a natural warmth, sense of humor, and an ability to put people at their ease. The high degree of autonomy required also dictates that people be able to function outside of an agency or office building, on their own in a neighborhood. While the applicants may not have had much relevant prior experience, some may have had volunteer experience working through their church.

Certain intangible criteria are necessary, such as reasonable maturity, self-awareness, tolerance, and independence. An interviewer should not totally ignore his intuitive hunches, his liking or disliking a particular candidate. There are several general issues which could bear examination. Mental health is an obvious factor, and one might be tempted summarily to disqualify anyone with a history of psychiatric or social pathology. Yet a worker trying to encourage a family to take advantage of a counseling service might have a much stronger impact if he could discuss his experience as a recipient of counseling himself. (One might even grant a candidate credit for past psychiatric treatment, as "relevant prior experience". Some professional mental health agencies do this, and

a few even require it . . .) It might also seem hazardous to hire someone in need of treatment, with the provision that he or she get counseling in order to keep the job. There are some New Careerists, however, who are perfectly able to separate personal from job problems, and who seem to function on the job even better because of their own personal difficulties. They are able to apply selectively to themselves some of what they are learning about others. I remember one worker who began using non-physical punishment with her children, found that it allayed some of her guilt feelings, and then joyfully reported her progress to a parent group discussing discipline. (There has been recent attention in the literature to the therapeutic benefits accruing to the "helper" as well as to those he is helping.)

The ambitious, upwardly mobile candidate raises several issues. An interest in self-betterment is a necessity on this kind of job, and one cannot expect a New Careerist to remain low-income all his life. He will probably want to "get ahead", but this must be balanced by the ability to accept another person's desire to remain just where he is. An overly ambitious worker, eager to leave the ghetto, may not understand why his client does not share this value. He may react to this client with impatience or even intolerance.

Admittedly these are vague criteria, and must be evaluated with reservation. For this reason there should be some way of gaining perspective on the whole person applying for the job. There seems to be considerable merit in a plan employed by the Temple Community Mental Health Center in Philadelphia. In brief, the pro-

fessional staff recruited a number of workers from low-income areas. These workers were hired for a short period of time, to run a survey in the various neighborhoods. This was not to be "busy work"; data on the various service areas were desperately needed, and the survey began to spread the program's reputation as well. But the chief value in this approach was as a selection device, an on-the-job evaluation of the native skills and potentials of each member of the group, from which could then be selected permanent staff of mental health assistants (New Careerists). There was no deception in this plan, as the group knew from the beginning that they would be evaluated for permanent employment based on their performance in the survey.

Another complex issue to be faced involves the attitudes and feelings of professionals about New Careerists. The entire staff needs to be involved in planning this new program, or at least kept informed as the plan develops; resentment and/or hostility could erupt if the finished product suddenly dropped in their midst without

Some professional staff may . . . be tempted to invest their new colleagues with magical or super-human abilities, simply because they are Black or poor.

any preparation. Even at best, however, a certain amount of ambivalence should be expected from some professionals, and this could persist, at least until the New Careerists have had a chance to prove themselves. The professionals may not feel sufficiently comfortable working with low-income and/or minority group people as colleagues. (It is one thing to work with a polite middle-class Negro, and a different task altogether to work with an angry Black militant.) These reservations can best be anticipated and dealt with if the ground work with

staff is carefully laid and if the New Careerists have very specific, clear assignments and tasks. This reduces staff anxieties concerning threats to professional competence and to traditional role definitions.

Some professional staff may over-react to New Careerists, welcoming them with open arms. They may be tempted to invest their new colleagues with magical or super-human abilities, simply because they are Black or poor. While this enthusiasm is laudable, it can lead to painful disillusionment later.

Some professionals may feel rather uncomfortable at the idea of participating in social action. These are tumultuous times, and social action seems to be linked to violence. It is not the author's contention that militant political action should be part of every professional's skills. But there needs to be a visible readiness, even an eagerness, to influence significant social change on a community level, if an established agency is to have any real hopes of working with a low-income client group. If the agency administration encourages this kind of community involvement, an enthusiastic staff should have little difficulty finding appropriate community problems, and community groups already looking for help to remedy these conditions.

C. Initial Training: The consensus among those with experience working with New Careerists strongly recommends the group approach to training. Not only is group training more economical of time and effort, but it also seems more effective. The individual New Careerist is far more accessible to attitudinal influence from a group of his peers than from almost any other source.

In the initial training, attention should quickly be focused on the specific nature of the job, with as much detail as is possible to define what is to be done, how it should

be done (or what alternative methods are available), and the timing that is expected of the New Careerists. At the same time, the various job-related anxieties should be brought up for discussion, as soon as the New Careerists appear able to cope with them, verbally. These feelings have been discussed earlier, in terms of the attitudinal shifts which the New Careerists have to make on the job. They may fully expect to assume a subservient, silent role, yet with undercurrents of fear, awe, and perhaps even resentment. They will probably be hyper-sensitive to perceived injustices or rudeness.

As soon as the initial orientation is accomplished, and the new staff has at least a rough idea of what their jobs are, some kind of practical exercise might be useful. Perhaps there are some specific assignments out in the field, such as attending a community meeting and reporting back to the group. This would provide an outlet for anxieties, so that everyone could start doing something job-related as soon as they felt ready. There would also be valuable feedback of experiences and reactions in the next training session. This would give the training staff some beginning information on what their trainees need to learn, both initially and later.

During the first two weeks, or longer, it might be advisable for the training and the entire New Careerist trainee staff to meet daily. As the New Careerists begin to get into their assignments, the meetings could shift to once every week.

When the anxiety level of the New Careerists is sufficiently low, but not before, then the necessary didactic training material should be considered. However, this type of presentation should be used as infrequently as possible, because of the emotional and social distance between a New Careerist trainee and the "expert". The

training staff should strive to make the lecture as active a learning experience as possible.

D. Ongoing Training and Supervision: The importance of the group process in initial training already has been stressed. The same applies to supervision throughout. (From the viewpoint of New Careerists, supervision and ongoing training are considered synonymous here.) A reaction session, following a lecture, film, or reading assignment, helps to integrate the new material into the job performance. A sensitivity session can increase awareness of per-

The training task is to find fairly basic mental and physical health principles and techniques that can teach a New Careerist to help parents deal with the normal problems of living, on a "family life education" basis.

sonal feelings, relative to a particular client, problem, or program innovation. (There is some controversy nowadays about "sensitivity training". The author is not suggesting the use of encounter groups, or any technique which might verge on group therapy. A clear line must be drawn between personal and job problems. There must be times, though, when New Careerists are free to "let their hair down", with training staff and with each other, and to relate on a real feeling level to job-related issues.) Besides allowing for ventilation, these meetings teach the need for growing self-awareness as an integral part of training to be a helping person. Not only must the feelings be recognized, they must be expressed in fairly accurate, understandable language. Professional jargon should be avoided unless or until everyone feels comfortable with it. These meetings will be helpful only if they can elicit real "gut-

level" participation, and this may be hard to initiate. The professionals may have to show the way by frankly discussing their own feelings, such as their frustrations at not being able to help everyone, or their need to appear "expert" to the New Careerists.

Role playing is a very useful technique for reaching and involving feelings as part of the learning process, as long as everyone can be supportive when mistakes are made. If the group is too heterogeneous or factionalized for group reassurance to occur spontaneously, then it might do better divided into smaller groups. Another valuable use of the group method is for an intra-staff evaluation of the program. New Careerists should have periodic opportunities to discuss their opinions about the program's strong and weak points. They might not think it appropriate to their role to ask for this, so it should be built into the program.

Individual supervision should not be totally discarded; each New Careerist should have a professional staff member available, in case there are learning or performance problems unsuited to group discussion. Some staff may need a referral for private counseling, for instance. After trying mandatory weekly or bi-weekly individual supervision for two years, however, the author feels bound to recommend against this technique. Required one-to-one supervision may place too much pressure on the individual New Careerist, which would make learning more difficult.

Records, time sheets, and general data collection are necessary for any program, and particularly for those using such innovative technique as New Careerists. It is safe to say that, no matter how little recording is deemed necessary from administrative and training viewpoints, this will be received unhappily by staff. (This reaction is, of course, not typical of just New Careerists.) Besides the benefits of training and

program feedback, record-keeping trains the staff in grammar, spelling, penmanship, in self-expression, and in the use of forms and other written procedures, all of which will be useful in later employment. Report-writing should be included in the initial job description, and should be discussed with every job applicant.

The training curriculum for the New Careerists will be discussed briefly. The actual plan should be responsive, both in content and in timing, to the needs and preferences of the New Careerists themselves. After the initial training is accomplished, and more general learning areas emerge, a staff meeting should be directed toward outlining a staff development program for everyone. New Careerist staff should receive college credit for these courses. The following subjects would probably come up:

Beginning interviewing skills will be asked for, and should include various alternative techniques of introducing oneself and the purpose of the interview; how to ask increasingly personal questions and how to judge when to proceed and when to stop; how to recognize nonverbal cues and one's own intuitive clues; different feelings which the interviewer might engender in the client, how to recognize and to deal with them; and the role of the interviewer's own feelings in the process, just to name a few. The entire staff would also have other particular areas that they would like discussed, such as how one interprets the agency program. Of course, the more standard interviewing techniques should also be included, particularly confidentiality.

Community and neighborhood resources represent another area that would need attention fairly soon. This subject should be re-examined periodically, in light of the staff's rapidly increasing experience in working with these various resources. If at all possible, the agency should initially

draw up and publish for its staff a brief list of all the appropriate community resources, with an outline of the eligibility process, intake routines, and key people in those agencies who might be most useful in the referral process. This should not rule out the necessity of field visits to these agencies; first-hand experience is the best background for making a helpful referral. But the information in writing will be a useful reminder, and it will also serve later as a framework for an assessment of the various resources. Which ones are used the most, which ones are the most discouraging, and why? (As Reiff and Riessman point out, the program goal is not just to benefit individual clients, but to urge changes in the service system as well.⁵ There are many ways to implement this, one being a documented assessment of that service from the client's point of view.)

A series of lectures on child growth and development should be instituted at some point in the program. This should have practical value for New Careerists in answering parents' questions on their children's behavior. The staff should have a framework around which to organize their growing knowledge about human behavior, and also a sound basis from which to advise and to counsel parents. The content here would focus on the entire family, and on techniques for promoting healthier family adjustments. There is a public health aspect to using New Careerists, both as case-finders and as "preventive experts", giving parents some anticipatory guidance on problems facing families. This role should be recognized explicitly in the training programs, so that New Careerists are cautioned against too blatant a use of their own values. The training task is to find fairly basic mental and physical health principles and techniques that can teach a New Careerist to help parents deal with the normal problems of living, on a

"family life education" basis. The New Careerist must know when he can reassure parents that a particular act or feeling is normal and appropriate, and when he should express concern and recommend certain coping techniques. (For instance, without training in the subject, a New Careerist might feel that he should help parents discourage their young child's thumb-sucking. Once he learns that this is normal and healthy for young children, he could reassure parents, and they in turn could relax. In this way, possible later problems might be averted.)

Summary

New Careers is a new and fairly revolutionary concept. There is little published material that attempts to provide guidelines for setting up and implementing such a program. The author has attempted to do this, by discussing the *New Careers* strategy and the assumptions that go into it, and by describing the planning process. Social action and the community's involvement in planning, are two outgrowths of the *New Careers*' philosophy that relate to working in low-income neighborhoods. These ideas may be troublesome to some professionals, and thus they are frequently ignored. Yet they are essential parts, if the program is to have maximum impact.

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APPENDIX I HYPOTHETICAL JOB DESCRIPTION—NEW CAREERIST MENTAL HEALTH WORKER

General task: Under appropriate supervision, serve as liaison between professional staff and certain low-income groups and neighborhoods.

Specific tasks:

- a. In conjunction with professional staff, organize, recruit for, and participate in neighborhood discussion groups, on a "koffee klatch" basis.
- b. Use neighborhood groups as a way to become familiar with the particular problems of the neighborhood, to introduce self and program, and to reach individuals and families who may need particular services.
- c. In the event that the discussion group program attracts considerable support locally, assess potential for continuing the service. Withdraw from the group in favor of either a parent education or social action resource in the community.
- d. Seek out low-income families and individuals in need of medical, economic, social, or mental health services.
- e. Become involved with specific families around particular social or emotional problems (either referred from the group or from other agencies or resource people known to the worker). Clarify problems, establish priorities from among these, discuss referral possibilities, and then make a referral when the clients are ready.
- f. Provide support, encouragement, "emotional first aid" while referral is pending. When appropriate, provide tangible support: Baby-sitting, transportation, translation, advocating client's rights, or other service. Continue working with family until referral is completed and service begun.
- g. Follow-up several weeks later on all referrals, to insure that the service is meeting the need, is useful to family, or if another referral is necessary.
- h. Participate in initial training, and in ongoing training and supervision as provided by staff. Prepare written reports as required plus additional assignments as requested.
- i. Submit regular reports on work accomplished, data gathered, people seen, and other statistical reports as required.
- j. Take on additional responsibilities when ready (such as supervising and/or training new staff).

Martin E. Danzig, Ph.D.

Education of the Community Mental Health Assistant: Dovetailing Theory With Practice

The author describes a two-year mental health curriculum for training mental health assistants. The curriculum combines principles of the behavioral sciences taught in the classroom with the learning experiences of clinical instruction conducted in a fieldwork setting.

There is common agreement about the need for the semiprofessional worker in mental health. The focus of this paper will be not so much on the "why" but rather on the "what" and the "how" of the training program for the Community Mental Health Assistant. The basic philosophy of the program will be briefly summarized while the shape and pattern of the program and the involved processes will be explored more fully.

College-Hospital Partnership

In February, 1968, discussions were launched between Kingsborough Community College and the New York State Department of Mental Hygiene to undertake

Dr. Danzig is the Director of Studies for Kingsborough Community College of the City University of New York, Manhattan Beach, Brooklyn, New York 11235.

a training program for hospital orderlies currently employed in State mental institutions, for the purposes of educating and upgrading these workers towards a professional level. The College opened the first class in September, 1968, composed of 22 students, representing seven hospitals, five State Mental Hospitals and two hospitals operating under private auspices. The hospitals released the students on a two-year educational leave, providing them with a basic salary.

The State Education Department approved the submitted curriculum for what would be called the position of Community Mental Health Assistant.

The Mental Health Curriculum

Generally, the curriculum represents a fine balance between the hopes for education and the need for the acquisition of

specific skills for agency and professional practice. In the Mental Health field, the objectives are based upon the particularized qualities needed of the hospital worker. They include:

1. Sensitivity to good human relationships.
2. Helping the individual who has been mentally ill to live with himself.
3. Appreciation of group living and social interaction.
4. Helping the mental patient to assume a measure of responsibility for self-management.
5. Helping the patient to return to his home, to his family and to his job.

These five objectives are the accepted goals for patient recovery as hoped for by the total mental health treatment team. The challenging task is to carefully select the areas of knowledge, skills, and attitudes essential for the emergence of an effective semi-professional. It may be more significant to begin with the last factor; that is, the attitudinal change that must be developed as the expected outcome of the program.

Expected Attitudinal Outcomes

The major question is: "What are the ideal attitudes that the student should develop?" There are four major attitudes that must be cultivated in order to enable him to function effectively when he returns to his new position at the hospital. These four learned predispositions involve the accepted philosophy for the community, social, preventive, and public health concepts of psychiatry and they comprise the following developed attitudes:

1. Patients in the hospital are viewed as members of social groups, rather than as sick people living in the isolation of the hospital.
2. The social determinants of behavior

are directly related to the genetic, psychodynamic and etiological factors in mental illness. The implication is that there must be some understanding of the patient, his role and status, his broad cultural background, and the kind of family life that he has experienced.

3. The concept of stress, as it is manifested in all of its aspects in interpersonal relationships, must be clearly understood. It is insufficient for the student to verbalize about the functioning of the ego in contradistinction to the patterning of the id, but it is extremely important for him to develop some insight about the identity crisis, particularly as it impinges upon the patient placed under his care.

4. The student must develop a unique sense of creativity and learn to utilize the wealth and resources of community facilities and agencies. Hopefully, this will eliminate the deep feeling of despair that perpetuates the custodial functions of the mental institutions.

To help students become aware of these factors, there are planned conferences with faculty members and field instructors, during which the student identifies his own feelings, receives guidance and exchanges experiences with other students.

The attitudinal change is responsible for the development of a semi-professional role. The attitude, in turn, is based upon the specific knowledge and skills developed in the curriculum. This leads to a discussion of the curricular design that facilitates such learning acquisitions.

Essential Mental Health Knowledge and Skills

The full curriculum outlined in encapsulated format, is available upon request. The philosophy and rationale will be discussed, followed by illustrations of the various curricular components.

Designed as a fusion of theory and practice it is comprised of five major components: the basic liberal arts education;

principles distilled from the behavioral sciences; distinctive concepts selected from community mental health and psychopathology; and basic agency practice by means of clinical field instruction. The uniqueness of this type of curriculum is twofold. On one hand, advanced knowledge in mental health that is usually acquired at the graduate level is paired down to meet the needs of the undergraduate student. On the other hand, concepts, principles and theory are tested in the rigors of professional practice. Thus, clinical instruction conducted in the field serves as the capstone for the mental health curriculum.

Liberal Arts Education

In keeping with the tradition of a liberal arts education, to stimulate the student for self-development courses include American literature, writing, music, mathematics, visual arts, American civilization, and the contemporary world.

Principles of the Behavioral Sciences

This course is divided into two parts: it summarizes the views of mental health spokesmen who have developed a conceptualized framework for the role of the semi-professional worker and stresses the course content of the behavioral science sequence.

The Philosophy of the Behavioral Scientists. George Albee in his fervent plea for the development of the paramedical worker indicates that there is a decided need for a breakthrough in the concepts of mental disease. Most causes and remedies of mental disorder and the roles of the entire professional field are dominated largely by the medical model with its concept of mental disease. Albee argues that in reality most mental disorders are primarily learned patterns of behavior based upon deviant socialization.

He suggests the development of a new approach, the formulation of a new social learning theory. Simply, this means that an emotional disorder is the learned behavior acquired by the individual during long periods of social interaction and social participation.

Others, such as Bleuler and Sullivan also indicate that there must be a fuller understanding of the psycho-social factors which influence the world of the mental patient.

Course Content. A second course entitled Human Growth and Development is devoted to the processes of growth, from infancy through adulthood, and the relationship between physical and mental development. The course includes a discussion of some problems encountered during the various stages of the life cycle.

The student is introduced to a fundamental course, Principles of Sociology, as a basic understanding of the environmental forces of society. Therefore, the nature of culture and its influence on behavior, with the emergence of cultural-pluralism and the various sub-cultures in American society, are underscored.

A second course, Social Problems and Agency Resources, includes a review of the most pressing current social problems emanating from the pressures of our industrial society. Above all, the course accentuates the possible solutions and choices for remedial action. This means that an array of community resources, including a wide choice of public and private agencies that are available for the mental health professional, are examined and assessed by the student.

A third course, The Sociology of the Family, covers the organization of the typical American family, emphasizing the essential emotional, psychological and sociological problems.

The final course, Cultural and Ethnic

Minority Groups, deals with one of the most difficult problems facing modern urban living. Such factors as ethnicity, religion, race, and social class that face the minority groups of our society are reviewed in great depth. Aware of the fact that the student frequently must work with minority groups and their families, this course develops a better understanding of the environmental forces engendered in our American society.

To round out the behavioral sciences, it is hoped to add at an appropriate time a minimum of one course in Cultural Anthropology.

The basic purpose of the neophyte is to serve as generalist and not as a specialist in mental health. As a generalist, he is educated in the broad principles of deviant behavior and not narrowly trained in a limited area.

He can function best when the model to be learned and followed is in the nature of a psycho-social rather than a medical model.

Psycho-Social Rather Than a Medical Model

The traditional view in psychiatry is that mental illness is a disease, and, as such, requires the full range of procedures developed in the field of medicine. Indeed, in mental hospitals there are a sizeable number of mentally disturbed patients who require intensive care and treatment by a medically trained psychiatrist.

In recent years, however, there has been a good deal of questioning of the medical model. Thus, for example, the American Psychological Association and the Committee on Labor and Public Welfare of the 88th Congress, in 1963, raised some serious questions about the traditional disease view of mental illness. The accepted medical model is primarily geared to the professional role and function of the psychiatrist.

In our program for the Community Mental Health Assistant the accepted hypothesis is that the training is entirely for that of a generalist for mental health and not the development of a new kind of specialist. Obviously, for this newly trained generalist, none of these professional tools is within his competence. This explains the logical approach that social disorders are based upon a psycho-social model, indicating that the patient has manifested some strange patterns of social functioning.

Educational theory suggests that prior to planning any curriculum, it is essential to clarify the objectives first and then proceed with their implementation. Accordingly, the following objectives have been structured:

1. To orient the student in a fundamental understanding of mental health and social disorders.
2. To develop some insight of the major clinical syndromes in the disordered behavior of the mental patient.
3. To provide some basic skills that the student can utilize in his involvement with the mental patient.
4. To understand the role he must perform in order to achieve the behavior modification of the patient.

Achieving these objectives means that teaching the student has been approached by demonstration, rather than concentrating on voluminous and weighty readings. Thus a good deal of psychopathology is learned from the experience developed in clinical instruction as conducted in the field. The selected readings are of a more popular form which complement the students knowledge. This requires the development of four areas: pathology of the personality; behavior modification; group dynamics and clinical instruction; or field work conducted at the hospital. Each one of these areas will be briefly explained.

Knowledge of Personality Pathology

A major focus in the learning experience of the student is on personality pathology, or learning the complex patterns of the behavior of mentally ill patients who are currently confined to the hospitals.

However, the student is not expected to master this knowledge but to understand his role as a semi-professional member assigned to the helping psychiatric treatment team.

Teaching the Methodology of Behavior Modification

Teaching the Community Mental Health Assistant the methods utilized for behavior modification does not require him to have medical training. On the contrary, some basic understanding of learning theory is far more essential. In other words, he must learn how to reverse or bring about a drastic change in the patient's behavior. On this basis the therapy prescribed by the psychiatrist can be followed through by the trained worker functioning in the day-to-day operations of the patient living in the ward.

Group Dynamics

The student is exposed to various aspects of group behavior in order to understand group functioning. The methodology utilized for the students concerns techniques of sensitivity training, or the more popular T-Group. This involves the student in a number of role-playing sessions. Above all, it helps the individual to become aware of himself as a member of the group, and, even more importantly, how he personally functions, and how his own behavior affects the other group members.

Clinical Field Work Instruction: Dovetailing Theory and Practice

The crucial test of the curriculum occurs when it is submitted to the crucible of professional practice. In order to dovetail the basic classroom knowledge which has been taught largely in a theoretical framework with the kinds of practical applications as demanded in the wards of the hospitals, it seemed best to follow the existing pattern of the wards available in the field work agency, the Brooklyn State Hospital, and to develop the curriculum accordingly. There are more than sixty major wards in the hospital and these are subdivided into: a. Reception or Intake; b. Geriatric; c. Alcoholic; d. Chronic Schizophrenia; and e. Continuous, or Intensive Treatment.

The students gain experience in these areas which permits the distillation of the essential concepts and principles that are basic to understanding mental health.

The theoretical content of the behavioral sciences courses is thus directly related to the realities that confront the student on the ward.

Other Learning Techniques

To assure that every student is exposed to the same kind of learning experience, several other techniques have been developed. Thus, for example, the principle of teamwork has been instituted. No student is permitted to work alone, but is paired with another student. This team of students must develop its own pattern of effective teamwork cooperation.

Second, the student is required to keep a daily log or diary that describes the actual contact made with the patient and the attempted interaction. Success and failure in reaching the patient are frankly recorded for future discussions with the instructor.

Third, these diaries are carefully read by

the course instructor and tested to verify the extent of the student's learning experience.

Fourth, the diaries are summarized and the student is asked to distill the basic principles of mental health that he learned in this experience of clinical instruction.

Fifth, a system of rotation has been instituted, whereby every team of students is assigned for a period of three weeks to each one of the five previously mentioned major hospital wards. Thus, the first semester is planned as a thorough orientation of every type of patient committed to the hospital. Above all, the knowledge of patient behavior is directly linked to the principles of mental health as developed in the literature and as evidenced by the assigned readings.

Sixth, during the second semester the student is assigned to a limited case load, from two to five patients, which enables him to bridge the gap between conceptualized theory and the direct application of mental health practice.

Seventh, the student's role as a helper to the treatment team is interpreted and the unskilled worker begins to develop insight into the kinds of problems that challenge the untrained ward attendant. This new discovery, in turn, leads to the realization of the kinds of functions that he can perform and the variety of services that he can render to the patient, to the treatment team and to the mental hospital.

Differentiating the Clinical Instruction Planned for Two Years

To differentiate the knowledge taught in clinical instruction during the two years of training, considerable precautions have been taken to structure entirely different learning experiences for each of the two years of training. During the first year,

the student will concentrate his learning experiences within the various wards of the hospital and the functions of the treatment team, as described earlier. The focus is on the institutional setting of the hospital, helping the student to become familiar with the kinds of patients and problems that are unique to each hospital ward. Moreover, adequate interpretation is made of the significance of the treatment team and the distinctive helping role that the student can develop.

A radical change in pace is made during the second year of clinical instruction. The focus of the second year learning experience is devoted largely to the kinds of problems that a patient will face when planning is undertaken for his return to the community. Therefore, the learning is concentrated on the following areas: the basic understanding of the identification of the community; specific knowledge of the variety of community agencies; the availability of community resources; and above all, the role of the family which ultimately might play a significant role in the patient's recovery.

This variation in program means that a similar change must be made in the field work agency for Clinical Instruction. This requires the selection of a mental health center, a halfway house, or some comparable agency which will enable the student to understand the mental health problems that are involved when planning is undertaken for the patient's return to his home, to his job and to his family.

Summer Program

The summer that intervenes between the two-year training program, is devoted to intensive hospital experience. This is achieved by assigning the student to return to his agency of origin. Careful follow-up and intensive faculty involvement of the

summer's experience assures that the mental health learning, achieved by the student during the course of his first year, will be broadened and deepened during this period. A final evaluation report indicates the progress that the student has made at the end of the summer's experience.

Conclusion

This article describes the mental health concepts, principles and theories drawn from the behavioral sciences. Knowledge derived from psychopathology and group dynamics is designed so that the educational principles taught in the classroom are matched with the learning experiences available in clinical instruction as structured in the field work agency. The basic approach built into the curriculum is to dovetail theory with practice. This goal is specifically achieved through the program of clinical instruction. During the first year of clinical instruction the student is exposed to the realities of "life in the hospital ward", which enables him to become familiar with the different types of patients and the variety of hospital ward operations. In the second year he learns to utilize the

community agencies and community resources. Above all, the student must learn the kind of role that he must play and the kinds of functions that he can perform that will prepare him to serve as a bona fide helper to the mental health treatment team.

The other dimension of Clinical Instruction is the realization experienced by the student that he has some basic limitations. The student becomes aware of the vast field of knowledge developed in mental health, in addition to developing an admiration for the expertise of the full-fledged professional members of the treatment team. He is aware that there is a great deal of information to be acquired and he can only serve in a limited, but effective capacity, as a semi-professional staff member.

Such innovations as the "open-door" hospital, the "day-and-night" hospital, the "halfway-house", and the newest development, the community mental health center, indicate that there is a decided role and function for a new worker in community mental health. The newest staff member, labeled as a generalist rather than another type of specialist, now emerges as a trained and useful semi-professional worker, the Community Mental Health Assistant.

David S. Shapiro, Ph.D.

Mental Health Professionals' Hang-ups in Training Mental Health Counselors

The mental health professional, who usually assumes responsibility for training mental health counselors, is handicapped by unfounded beliefs about the division of mental health responsibility and competence, the suitability of psychiatric curriculum in inter-professional training programs, and existing mental health functions and conditions of practice of other professional groups. Trainers must (1) identify and overcome unfounded "myths" which are barriers to communication and collaboration: (2) study each profession's functions, traditions, existing mental health role, and potentialities: (3) make the training a collaborative endeavor: (4) focus much of the training in the community in a format that facilitates the assimilation of appropriate changes in professional practices.

Introduction

This paper has as its purposes: (1) to emphasize the critical importance of programs designed to train large numbers of mental health counselors; * (2) to discuss

David S. Shapiro, Ph.D. is lecturer on Social Psychiatry in the Department of Behavioral Sciences at the Harvard School of Public Health, 55 Shattuck St., Boston, Mass. 02115. He was formerly Director of Training and Education and Chief Clinical Psychologist at the Bradley Center, Columbus, Georgia, where the field work upon which this paper was based was conducted.

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what we consider to be misconceptions on the part of many members of the mental health professions which lead to an inability to communicate with, and work creatively with competent members of other professions who can function effectively as mental health counselors; (3) to outline, in broad terms, a strategy for the large-scale training of mental health counselors so that eventually a wider range of helpful services will be available to emotionally and socially troubled individuals.

The opinions, observations and viewpoints reported here were gathered and

* Professional persons who have a helping relationship with large numbers of people and who can be prepared through short courses and consultation to give more effective assistance to troubled people. (Joint Commission).

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formed during a ten year period during which the author and his associates^{6,7} developed and demonstrated a mental health training program for various professional groups. In the course of training a total of over 1,000 physicians, ministers, public health nurses, welfare caseworkers, rehabilitation counselors, guidance counselors and others, it was inevitable that we would learn a good deal about the problems, resources, needs and conditions of practices of these professional groups. In this paper there will be some discussion of "myths" of the mental health professional. These represent observations about unfounded beliefs, preconceptions and attitudes which, in our opinion, serve as a barrier to productive interprofessional co-operation and training for meeting human needs. The intent of this discussion is essentially a positive one; to assist the mental health professional to identify and overcome unnecessary barriers to his more productive participation in community mental health efforts of inter-professional and inter-disciplinary nature.

The Mental Health Professions: Our Myths and Misconceptions

Any community-wide program attacking the social problems of mental ill health must receive a generous contribution of skills, leadership and knowledge from the mental health professions. Since many psychiatrists, psychologists and psychiatric social workers were educated and trained in settings where little attention was given to the mental health functions and responsibilities of other professional groups, attitudes towards these groups were usually formulated upon the basis of little systematic information and even less research. These attitudes and beliefs form a mythology that may be quite harmless when its holder operates within the confines of a

It appears to be entirely reasonable to suggest that more of the mentally ill are treated by general physicians, and other professionals than are treated in all our clinics and hospitals.

mental hospital or clinic. When the mental health professional attempts to apply these myths in working with and training other professional and non-professional workers, the results may be quite unfortunate.

Some of the key myths which may interfere with proper interprofessional relationships are as follows:

Myth 1.

The mental health professions are the primary source of help for and the exclusive caretakers of the emotionally and mentally ill. This assumption does not stand up when we examine the most conservative figures about the prevalence of such illness. There is a reasonable basis for assuming that other professions, knowingly and unknowingly provide supportive and treatment services for a large number of such persons. It appears to be entirely reasonable to suggest that more of the mentally ill are treated by general physicians, and other professionals than are treated in all our clinics and hospitals.

Myth 2.

Competent psychiatric services are the optimal form of help for all forms of mental and emotional problems. It would be more reasonable to state that psychiatric and mental health services are moderately successful in treating individuals falling into a relatively narrow range of the full spectrum of disorders. Thus, many leaders acknowledge that psychiatry has relatively

little to offer to the alcoholic, the character disordered, the poorly educated and the inarticulate.

Myth 3.

Other professionals are essentially amateurs in the mental health field who with careful supervision, can be trusted to act as casefinders and referrers. This again is an unwarranted and often unjust assumption. Professionally mature people who are used to assuming responsibility in the many crises of life, growth, and death, as do physicians, ministers, nurses, caseworkers and others, do not deserve to be treated with a lack of respect for their competence.

Perhaps the gravest error in this assumption, is the naive belief that mental or emotional functioning can somehow be separated from the rest of life. It cannot: the competent physician deals daily with the mental ills which impinge upon the physical health of his patient: the minister helping a parishioner to find himself through faith and belief and participation in the fellowship of the church, knowingly, or unknowingly deals with the emotional ills that beset him.

Myth 4.

Mental health training for the nonpsychiatric professions should be similar in design, objectives and content to the training of mental health professionals. Psychiatric and psychological personality theories, terminology and psychotherapeutic methods form an ideal curriculum for such training. While there are many principles and practices that the mental health professional can profitably share with other professions, it is unsound to assume that there can and should be a wholesale transfer of principles, terminology and practices. Every profession has its own history, traditions,

body of knowledge, roles and conditions of practice. An attempt to indoctrinate other professions with the full range of psychiatric attitudes, theories and practices may actually lead to impairment of professional identity and competence.

Myth 5.

Mental health training whether in the form of carefully conceived courses or training programs at the university or training center, or in one or two day mental health workshops, automatically lead to the use and application of these skills and ideas in the professional practices of the individuals thus trained.

Conversations with many physicians and ministers who have had varying degrees of formal and informal mental health training lead us to suspect that much of the practical value of training is lost in transit from the training center to the office or study. The reason for this appears to lie in the lack of a bridge between the theories taught and the concrete means to put these skills to work in the hectic life of the busy practitioner.

Key aspects of a point of view regarding the relationship between the mental health professional and other responsible professional groups may be summarized as follows:

(1) Mental and emotional ill health is a general social problem and is a proper concern of all responsible professional groups and of political and community leaders as well.

(2) Many mental health professionals are severely handicapped in participating in productive inter-professional training and consultation programs because of attitudes which exaggerate their own importance, cause them to perceive the care of the emotionally ill as their exclusive domain and

Too often mental health personnel who plan training programs for other disciplines are unaware of the day-by-day demands upon the time and skill of the professional involved.

overlook existing and potential mental health functions of other professional groups.

(3) Training programs for the "mental health counselors" from all appropriate professions must be carefully developed in terms of the professional roles, skills, conditions of practice, pattern of existing professional duties, opportunities for mental health functions and specific needs for additional skills.

A Strategy for the Training of Mental Health Counselors

The task of providing mental health services, defined broadly to include detection, treatment and prevention is sufficiently large and complex to require participation of all competent professional and non-professional resources which may be made available. The mental health specialist has the responsibility of focusing his scarce clinical skills where they are most needed and where they cannot be duplicated by the mental health functions of other professions. There appears to be a growing body of evidence and opinion that an unduly large share of psychiatric services is devoted to the less severely disturbed, better educated and more resourceful group of patients while the more severely ill, socially disadvantaged groups tend to experience some degree of neglect.^{2, 5}

Assuming that psychiatry will tend to redistribute services on the basis of urgent need, it is probable that the problem of a

lack of services for mildly and moderately disturbed individuals will become more severe. A sound approach to this unmet need for services would be to reserve a portion of the time of capable mental health professionals for training other professionals in carefully conceived programs so that they may play an enhanced role in the mental health endeavor.

The mental health counselor should come from those professions whose specific duties are to teach social, emotional, occupational or spiritual skills and those professions engaged in providing a wide range of remedial or healing services. Among the key professions are the educators, the ministers, the physicians, the nurses, the welfare caseworkers, the lawyers and others. They require those skills which may make them more perceptive of early signs of failure or conflicts, sufficient understanding of human behavior to explain the general source of the failure so that they are ultimately able to do a more effective job in completing their unique professional tasks.

The following are considered a set of principles which may be helpful in developing a comprehensive approach to the training of non-psychiatric professionals to function as "mental health counselors":

(1) The full range of existing professional duties and responsibilities must be understood. Too often mental health personnel who plan training programs for other disciplines are unaware of the day-by-day demands upon the time and skill of the professional involved.

(2) The full range of existing mental health functions and responsibilities of the profession must be studied, acknowledged and respected. The preventive function of the professions is one that is often overlooked both by the mental health trainer and the professional himself. The educators who are part of a school system pro-

ducing a high percentage of individuals prepared to become self-supporting, productive citizens are obviously preventing some amount of illness. The physician who prescribes and teaches good health habits, and who supports his patients through fear provoking illness is performing preventive services. The minister who stands by his parishioners in times of crisis may be seen as preventing much failure and suffering. It would be possible to catalogue many existing and potential preventive and mental health activities of the professions; however, the significant point is that any individual who aspires to participate in their training for mental health work must be aware of this.

(3) A condition of genuine interprofessional collaboration should be established for the planning of mental health training programs. This collaboration is essential for the following reasons: (a) the mental

The mental health counselor should come from those professions whose specific duties are to teach social, emotional, occupational or spiritual skills. . . .

health professions cannot possibly understand fully the professional functions, mental health responsibilities, potentialities for improved mental health functions and specific needs of a given profession without a constant exchange of opinions and information in an atmosphere of equality and mutual respect; (b) the unilateral assumption by one profession of responsibility for part of the training of another profession may lead either to a hostile rejection of such interference or an overly enthusiastic and inappropriate acceptance of the other

profession's concepts, practices and professional role.

(4) The role and responsibilities of a profession must be respected at all times. Mental health trainers must resist the temptation to redefine the functions and roles of other professions in the interest of promoting better mental health. All professions are growing and changing as a result of new demands and needs. The nature and pace of such changes should be determined from within the profession in a manner consistent with their history, tradition and responsibilities.

(5) Training must be designed to provide the profession with that body of knowledge and skill which is required and which can be incorporated into normal professional duties and practices. It should not be assumed that a curriculum which is useful in the training of mental health professionals is entirely appropriate for other professions.

(6) The professional person must have a conceptual framework for studying and understanding human behavior. The approach must be sufficiently broad in scope to cover the spectrum of problems people bring to him. It must be rational and understandable to both the professional, his client and his peers in his own and other professions.

(7) The barrier between theory and practice can be overcome by conceiving of the preparation of "mental health counselors" as a two-stage process. The first stage, to take place during his initial professional training, will tend to have a heavy emphasis upon theory because of inevitable lack of mature professional experience. The second and most crucial, stage of training should take place after the professional has entered practice and has a clear identification with his primary professional functions. This stage of training must include

preparation in the actual tools and techniques for carrying out the various mental health operations required of the trainee within the limits of his available time and competing professional responsibilities. Much of the second stage of training should take place in the community itself.

(8) Training in the community should extend over a relatively long period of time, requiring only a small, regularly scheduled commitment of time. The incorporation of new knowledge and practices must proceed slowly. An intensive training course lasting days, weeks or months may provide more immediate gratification and stimulation but much of the benefit may be lost when the professional returns to his routine duties. If he is a mature, stable person, he will not introduce radical changes in his practice. He will, more likely, test out new ideas and practices slowly and accept them only as they prove useful. If he maintains contact with the instructor during the period of experimentation with new approaches, he is more likely to overcome the frustrations and inertia which often defeat attempts at innovation.

The Need for Debate and Imaginative Programs

The author has presented a series of observations and points of view based upon ten years of field work and research in mental health training for various professional groups.⁶ The approaches suggested here represent simply one way of reacting to a grave challenge to the mental health professions: the fuller utilization of existing and potential mental health manpower. There are other approaches and viewpoints which may be of equal or greater validity than those presented here. What is urgently

required is a greater amount of imaginative debate and innovation in this area.

The mental health professions have accepted a commitment to provide a significantly higher quality of services to a vastly increased population of consumers. This promise can only be fulfilled when all of the responsible institutions and professional groups are fully engaged in this task. The breaking down of barriers to meaningful inter-professional mental health training and consultation represents an item high on the agenda.

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Donna Hawxhurst, M.P.S.
Hank Walzer, M.S.W., A.C.S.W.

Patients Helping Patients

Friendship Club

In 1965 the Boulder Mental Health Center added a social club to complement and broaden the range of existent aftercare services. The club was conceived with the idea of providing a socialization experience for those post-hospital patients whose object relations were lacking or shallow. The socially isolated individual who feared meaningful contacts with others would be afforded a group experience. The social club would form a bridge back to the wider community.

A paid part-time group leader and volunteers from the local university comprise the staff which meets with the members one half-day a week. Excursions, bowling and picnics are now a continuing part of the program. Visits to shops and local places of interest enable members to move freely about the community and be exposed to community facilities and resources.

Group discussions are task centered and

often concern program planning and club functions. Formal group therapy is not a part of the program, and expressions of strong affects or "clinical material" is uncommon. The goal is to support and maximize healthy ego functioning.

One might divide the group into two segments. The largest segment, consisting of six or eight members, represents the chronic schizophrenic, who has spent from ten to twenty years in the State Hospital. Most of these have no family ties and are living in foster homes. Several have part-time jobs and several more have indicated some interest in obtaining work. This group tends to see the club as an end in itself and looks forward to the recreational activities and comfortable relationships with other members and staff. Ages range from forty to sixty and the majority of these members are men, although initially there were more women represented.

Another segment represents the more mobile membership who tend to see the club as a means to an end—a potential vehicle for more effective adjustments beyond the group itself. Although individuals in this group may have a history of chronic emotional disturbances and repeated hospitalizations, their hospital experiences have not extended over a long

Miss Hawxhurst is a doctoral student in counseling at Arizona State University. At the time this paper was written she was a counselor at the University of Colorado and a group leader in the aftercare program at the Boulder Mental Health Center. Mr. Walzer is executive director of the Mental Health Center of Boulder County, Inc., 3450 Broadway, Boulder, Colo. 80302.

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period of time. They are generally younger than those members discussed previously and become impatient when they feel that they are not personally profiting from their membership. This group represents most of the turnover that occurs within the membership of the club. The total membership of Friendship Club ranges from ten to fifteen, with an average attendance of twelve.

The description of the ongoing club activities and purposes thus far discussed is consistent with sound traditional social group work theory and, if you will, good "moral treatment" based on a high valuation of the individual.

Another emphasis was added when a new group member, with numerous psychiatric hospitalizations for chronic paranoid schizophrenia, injected "new life" into the club. She proposed that "all of us stop thinking of ourselves and do something for others for once." Her admonishing attitude immediately heightened the anxiety level of the club members and was met by a prompt rebuke—silence.

The staff encouraged the challenger to exert leadership in this direction and attempted to involve the other members in a supportive fashion. As it turned out, one of the more reluctant members, who initially was quite threatened by the confrontation, suggested that the club alter its plans for an Easter party by sponsoring an Easter egg hunt for a group of retarded children. The members became involved in plans for the party, but the real rewards were evident on the day of the hunt, when one could observe the enthusiasm and warmth with which the aftercare patients aided the children in their search for the colored eggs. Their enthusiasm was reinforced by recognition from the children and their teachers, and later by an article and picture in the local newspaper.

The members all agreed that they "liked

the feeling" of having done something worthwhile for others and that they would like to attempt a similar project. After exploring several possibilities it was decided that the group would visit one of the nursing homes in the area and plans were made for initiating a contact. A refusal by the director of the first home contacted to allow ex-psychiatric patients to visit stimulated a discussion regarding community attitudes toward mental illness and methods for coping with negative attitudes. They continued with their plans to visit a nursing home by making additional contacts which resulted in a proposed visit to a home selected by the group. Prior to the visit, many of the members exhibited anxiety, anticipating that they would have difficulty interacting with the elderly patients. To alleviate these fears, one meeting was devoted to a discussion of conversation topics and methods, utilizing role playing to provide practical experience. After a successful visit to the nursing home, the members displayed mixed emotions in their discussion of a proposed second visit to the home. It appeared that the institutional setting was a rather grim reminder of past experiences for most of the members. They unanimously agreed not to return. An acceptable alternative was suggested, however, and initiated when the members decided to invite several ambulatory nursing home patients to a picnic—a highly successful project.

Another "helping" project was assumed by the club when the members agreed to help prepare a new halfway house for occupancy. The Mental Health Center was planning to use the new facility as a transitional setting for discharged patients from the Colorado State Hospital; the club members were very much identified with the need for the home. Although the group's enthusiasm dwindled as the prospects of washing cupboards, moving furniture and

cutting grass became reality, the leader reminded the members that they had made a commitment, and the members agreed that they were responsible for "seeing it through" to completion. The group became more involved with the approaching arrival of the new occupants, and spent several meeting days preparing food and planning a dinner to welcome them. Verbal and written recognition came from the Mental Health Center, which served to reinforce feelings of having done something of value for other significant individuals.

During the past year it has been most encouraging to witness changes among individual members and within the group itself. The members have shown an increased interest in and concern for each other and the staff, as well as events occurring around them. One member who, for a year, had refused to actively participate in the group, may now be seen reacting emphatically to a group proposal. This same woman led several songs when the group entertained at a nursing home, at times singing "solo" before the entire group. Another woman who had consistently exhibited psychotic behavior in the group meetings has become an active contributor. Recently, she suggested that the club plan a picnic for the managers of foster homes in which a number of the members live. She is now known as the "expert chicken fryer" among the group after successfully assuming full cooking responsibilities for a club picnic. It is interesting to note that this particular member has taken her new role back to her foster home, where she is assuming some cooking responsibilities for the first time.

The Friendship Club has been operating with a new tone and tempo and the future looks optimistic. The members have needed and will continue to need encouragement by the staff if the club's orientation to com-

munity service is to survive. Many in the group continue to see the club as an end in itself and would be quite happy if the club were to exist only as a recreational-social facility for them. The philosophy under which the staff is functioning has created some new anxieties among some of the members—anxieties which may be necessary for commitments, action and individual progress.

Conclusions and Practice Implications

Erik Erickson,² discussing the importance of mutuality, states, "... truly worthwhile acts enhance a mutuality between the doer and the other—a mutuality which strengthens the doer even as it strengthens the other."

Likewise our experience has led to the realization that the assumption of the helping role by former patients engenders a mutuality between the doer and the other which can lead to a more meaningful social identity. Validation of socially acceptable behavior is confirmed through the helper role. The negative identity of the patient finds symptomatic expression in passivity and helplessness while active mastery is developed through the helper role. Frank Riessman,³ discussing "The Helper Therapy Principle," concludes: "Conscious planning directed toward the structuring of groups for the widest possible distribution of the helper role may be a decisive therapeutic intervention, a significant leadership training principle, and an important teaching device."

Nevertheless, a danger inherent in social clubs (the Boulder Friendship Club included) and possibly in day care hospital programs are lapses into over-emphasis on recreational or avocational activities. John Beard,¹ Executive Director of Fountain House, states:

Too often, . . . therapeutic efforts . . . become equated with a well-run, but essentially recreational program. Certainly the problems of the patient extend far beyond the need for a pleasant place to sit, to relax, to talk, to watch TV, to be alone or to engage in a variety of classes and activities. Yet increasingly, this emphasis tends to become the dominant feature.

While not negating the therapeutic value of these activities, it may be that an overemphasis on such routine daily activities reinforces a negative patient self-image. An overabundance of these activities is inconsistent with the real world adult tasks of breadwinner, homemaker, and community participant. Expectations of patient performance may be diluted and regressive dependency inadvertently encouraged. Simmons and Freeman⁴ in *The Mental Patient Comes Home* conclude that high expectations are associated with an absence of symptomatology. "Our findings suggest that . . . current notions of permissiveness and reduction of stress need to be re-examined both with respect to in-hospital and post-hospital programs;" and Erik Erickson,² writing as a staff member of the Austen Riggs Center, an open psychiatric hospital and research foundation, points out:

We experience surprising examples of initiative among our patients wherever and

whenever we ourselves can overcome certain diagnostic and prognostic prejudices by which we tend to overprotect them and simplify our task 'for their own good.' . . . under the guidance of a professional teacher, our patients run a nursery school open to the children of the town. Before parents brought their children, and brought them again, we would not have thought this possible.

The developing thrust of the "Friendship Club" is in the direction of performing socially useful tasks which will bring a degree of social recognition and wider community acceptance. We believe the negative social identity of members will be modified as they come into meaningful contact with others.

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Cyril M. Worby, M.D.

The First-Year Psychiatric Resident and the Professional Identity Crisis

First-year psychiatric residents face problems in establishing their professional identities. These can be seen in such areas as: ambiguity about role choice; intimacy with patients; relationships with peers, authority figures and members of allied disciplines; definition of therapeutic goals; and acceptance of the public nature of the work. The author suggests that supervisors be aware of these stages of development as an aid in structuring the psychiatric residency.

An examination of the process of becoming a psychiatrist seems timely in view of the current demands placed on psychiatric residents to function in multiple roles, utilizing a wide spectrum of techniques in a variety of settings. In this paper, I will focus on the first year of residency as the first of a series of sequential phases and will discuss some of the central tasks confronting the resident during this phase.

Erikson's concept of identity crisis may be useful in illuminating the psychiatric resident's experience of his first year.¹

Professional identity (work identity) may be viewed as part of the larger issue of personal identity. The requirement to compare, contrast and integrate a newer professional identity (that of psychiatrist) with an older one (that of less differentiated physician) often may revive conflicts related

to earlier developmental eras. "Who I am" in my eyes and "Who I am" in the eyes of others will become urgent issues once again.

A dramatic shift in perspective is required of the beginning resident as he reorganizes his self-image as a physician. The engagement of the following tasks appears central to the achievement of this reorganization.

Commitment to new professional role identity: Problems of loss and ambiguity

The act of entering the psychiatric residency simultaneously requires a choice of

This article is based on remarks made at the Annual Meeting of the American Psychiatric Association held in Boston, Mass. in May 1968. For a four-year period (1963-67) Dr. Worby served as clinical director of a 28-bed inpatient unit at the University of Rochester Medical Center. Eight consecutive groups of four first-year residents rotated through the unit for six month periods. This program is supported in part by grants MH 11668 and MH 7521.

Dr. Worby is Assistant Professor of Psychiatry and Director of Family Studies and Treatment Program, Dept. of Psychiatry, U. of Rochester School of Medicine and Dentistry, Rochester, N.Y. 14620.

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a specific discipline and an abandonment of other possibilities. Particularly in the first year, many residents mourn the loss of other possible role choices and experience a period of ambivalence as they deal with the necessity of making a personal commitment to the field of psychiatry. Commonly, the resident finds it difficult to form an image of himself at some future end-point. By contrast, the surgical resident, for example, is in a position to project himself into the future by visualizing the procedures he will be called upon to perform. The surgical resident has some sense of being given responsibilities in a graded hierarchy of complexity as his training proceeds.

This is less so for the psychiatric resident. Intermediate stages and end-points are more amorphous. Another factor contributing to a resident's hesitancy about making a commitment to the field of psychiatry is the ambivalence with which the field is viewed by physicians in other disciplines.^{3, 4}

**Intimacy and closeness with patients:
How much and in what ways?**

Each resident faces the task of defining the depth and the ways in which he and a given patient may relate to one another.¹⁰ It becomes essential for the resident to be sufficiently flexible to suit his approach more to the requirements of the clinical situation and less to the requirements of his personal needs and current theoretical

Relationships with peers, authority figures and members of allied disciplines

The relative independence of authority achieved by the physician prior to beginning the psychiatric residency is immediately challenged upon beginning the first year. Whatever his age, whatever his previous accomplishments, the beginning resident is viewed—by himself and others—simultaneously as an expert and a novice.⁹ In his acute need at the outset, he seeks and is receptive. Rebellion, however, is not far behind. The extent of the rebellion and the forms it takes vary considerably.

Sharing the patient with others

Some residents find it difficult to accept the fact that a patient has deep and meaningful relationships which antedate the resident's own relationship with the patient.⁵ He may respond to one side of the patient's ambivalence—the hostile feelings toward the parents, for example, without recognizing that feelings of love may be repressed as a defense against fear of engulfment with a consequent dissolution of ego boundaries.⁸ Furthermore, the resident often finds it difficult to appreciate the importance of newly established relationships on the floor—relationships with other doctors, nursing staff and other patients. These other parallel relationships often serve important transference functions, allowing the patient to experiment with the

Not infrequently a resident may become doubtful about his self-worth and his suitability for the field of psychiatry.

bias. The fact that a resident's models manifest a wide range of theoretical belief systems and actual behavior makes the issue more perplexing for him.

expression of deeply repressed and—in the patient's view—highly dangerous affects toward objects with whom there is much less at stake. Occasionally, a resident's competi-

tion with others for the patient becomes a central issue. Not infrequently, the discharge of a private patient with whom a resident has had a long and meaningful relationship is followed by grieving and/or acting out.

Defining therapeutic goals

In other words, coming to terms with who wants what—and how it needs to be. A patient and a resident enter into a relationship through the act of a third party; they are assigned to one another. The expectations each may have of the other may be quite divergent. It becomes a basic task for the resident to make explicit for himself what his goals are, what the patient's goals are, and what clinical reality requires. At times a resident's goals are not appropriate to the clinical situation. He may want more of the patient than the patient is capable of. As a consequence, the resident may become too intrusive, too demanding, too unappreciative of the role defenses serve to maintain the integrity of the personality. On the other hand, the resident's need to disengage from the patient may be so great that he fails to become sufficiently involved and challenging to the patient. In neither case has he served the patient's best interests.

Coming to terms with the public nature of his work

The resident on the inpatient floor is under the constant scrutiny of staff, peers and patients from the first moment he arrives on the floor. On July 1 he appears on the floor labelled an assistant resident in psychiatry. During the previous weeks, patients and staff have been dealing with the coming loss of residents they had been working with for many months. The new resident, within his first week, is expected to function as his predecessors had, and much

of this functioning is in public group settings. It is a challenging and painful time for all concerned.

Period of therapeutic nihilism

At some time in the first year many residents experience grave doubts about their capacities to be generative and useful within the field of psychiatry. They are exposed to a variety of teachers who serve as models, yet despair over being able to either imitate the teacher's style or develop a style of their own. Not infrequently a resident may become doubtful about his self-worth and his suitability for the field of psychiatry. Other residents experience a period of cynicism and therapeutic nihilism: they attack the field, its assumption, its techniques and its slow results. From the resident's point of view, the opportunities to be of help and the availability of means to be of help seem separated by an enormous and unbreachable gulf.

Implications

The early phase of a resident's development as a psychiatrist has been viewed as a normative professional identity crisis because of the demand for a radical shift in perspective in a relatively short period of time. It needs to be stressed that identity crisis as an inner experience is not viewed as a psychopathological state, although some residents may develop overt symptomatology during this phase.⁷ It is not only a time of anxiety and pain but a time of intense engagement, discovery, challenge and hope. The question requiring close scrutiny by those responsible for structuring the educational experience of the developing psychiatrist is this: given the developmental needs of the psychiatric resident, what are the environmental contexts which will promote his growth? This question has

been already asked by some and traditional ways of structuring the psychiatric residency are being challenged.^{2, 6} In my view, a developmental perspective of the residency may clarify how the phase-specific needs of the resident and the increasingly complex requirements of clinical work may be more realistically integrated.

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*I draw circles of
Dread
In the gravel,
Make squares
Of fear.
Smiles all around me,
Longing glances to drown me.
I turn the stone
To touch
The moist face
Of Doom.*

—Annie Wu

W. George Scarlett

The clergyman's role and community mental health

The clergy are often considered primary case-finders and caregivers in the context of a community mental health program. The author points out that if the clergyman is to fulfill his calling, he must be concerned not only with service to his fellow man but with the salvation of those who seek his help. His essential tasks are not those that deal with psychological problems. Until the clergyman comes to grips with this duality he cannot play an effective role in the community and remain true to himself.

Much hope has been placed in the community mental health movement with the idea that prophylactic medicine is one answer to the shortage of facilities for those who do get sick. More and more psychotherapists are taking on the task of teaching community leaders and any member of the community who may play a part in preventing serious mental disorder. The clergyman is one such individual.

But the growing involvement of clergymen in community mental health has led to a certain amount of confusion as to what are the essential tasks of the ordained minister. By essential, I mean those tasks which separate the ordained minister from other types of ministry. This paper is intended to clarify how the clergyman and psychotherapist are thought to be allies and how these thoughts relate and fail to relate to the job of being a clergyman.

Many professionals in psychotherapy seem to be saying that the clergy constitute one of the "helping" professions. Those involved with community mental health pro-

grams look at the large percentage of people with emotional problems (42% according to one report) who seek counsel first from their minister or priest. They conclude that the minister or priest is a key figure in the community so far as mental health is concerned, especially in dealing with crisis situations.

Feelings of unworthiness, hopelessness, and fear of the future theoretically have their answers in the Christian promise that God loves us; and the strength that comes from such a realization should theoretically be enough for a person to become involved in the world and to find meaning in this involvement. In practice, there are no doubt many cases where through the work of a clergyman such a psychohygienic transformation takes place following one's adoption of a faith.

These are some of the arguments for involving the clergy in community mental health programs. However, more than just arguments help explain the growing involvement of clergymen in this area. There are historical developments which have created a situation in which some clergymen welcome the opportunity to meet such a concrete need as the one spelled out by

Mr. Scarlett is a graduate student in psychology at Clark University, Worcester, Mass. 01610 and a divinity student at the Episcopal Theological School in Cambridge.

psychotherapists. Throughout the course of church history, the role of the clergyman has been shaped according to the demands of the culture. In the history of our own culture, we have seen the clergyman assume the role of the wise holy man. In some cases, such as when Catholic immigrants poured into this country in the second half of the nineteenth and early part of the twentieth centuries, we have seen the clergyman as-

The demand for "relevance" has ironically brought the clergyman near the state of being irrelevant to his vocation. What is more, it has led some to overlook the fact that the Christian faith cannot always be said to have a psychohygienic effect upon people.

sume many roles at once—that of social worker, counselor, educator, and spiritual leader as well. Now it seems that we are no longer asking for a holy man; we have professional social workers, professional teachers, and psychotherapists have taken over the area once monopolized by the clergy.

The result has been that many clergymen feel a real identity crisis. Symptomatic of this crisis is the advent of the so-called "hyphenated priest," the priest or minister who also has a degree in social work, or psychology, or law, or whatever. It is not uncommon to find him more attached to his secular discipline than to the discipline of theology. Within theological education itself, one finds a growing emphasis placed upon training in counseling and upon so-called 'field education' which may include anything from church school teaching to work done in some anti-poverty organization. All of these developments have arisen

as a result of the felt need by clergymen to redefine their roles and be more "relevant" to the needs of society.

But the demand for "relevance" has ironically brought the clergyman near the state of being irrelevant to his vocation. What is more, it has led some to overlook the fact that the Christian faith cannot always be said to have a psychohygienic effect upon people. Christianity can be as disturbing as it is consoling. Psychotherapy would have us recognize our inconsistencies and make the necessary corrections. As the philosopher Ernst Cassirer once wrote, "Religion is . . . , so to speak, a logic of absurdity."² It must never be forgotten that the Jewish and Christian religions are historical in nature and not scientific. That is, they take their understanding of man and the universe primarily from scripture and church history. In brief, we cannot avoid the fact that the premises upon which the clergyman acts (or should act if he is true to his "call") are radically different from the premises upon which the psychotherapist acts (or should act if he is true to his call). The ordained minister's primary task is to witness a faith, and the faith he witnesses may to many psychotherapists be quite irrelevant and even inconducive to mental health.

The ordained ministry arose historically and continues to exist today in order to keep the community in touch with its origins. What is happening today is that we have interpreted the ordained minister and religion in general to be private phenomena when in fact they are primarily public. The ordained minister is the one who has been given authority to lead the community in worship, to preach the Gospel in public gatherings, and to administer the sacraments. It is the public nature of the ordained ministry that psychotherapists have overlooked in their soliciting the aid of clergymen; it is this public nature that many clergymen have forgotten in over-

emphasizing their role as counselors. This is not to say that a clergyman cannot be a counselor. He may be that or a multitude of other things, even a tent-maker. But these other activities are essentially irrelevant to the tasks implied in his ordination. The sociologist Peter Berger writes: ¹

(Even if the parish ministry changes a great deal) . . . the essential problem for such as you (clergymen) will remain the same. You will still be called to get up on your little box and tell the same old story. The question remains whether you'd be willing to do so, at the human cost that this will inevitably exact.

However much psychotherapists and some clergymen wish to maintain that the clergy are "caretakers" and "helpers," the fact will remain that the special ministry to which they have been called is not defined in these terms.

That the job of the clergyman is to repeat "the same old story" will never be acceptable to those who do not take that story seriously. The clergyman will always be accused of being "irrelevant", and some clergymen will take that accusation and submit to it. But the majority will realize that though good theology is conservative theology inasmuch as it illuminates a very old tradition, the tradition itself is far from being conservative, for it demands alienation from the structures of this world while at the same time it demands a ministry to structures. In other words, unlike other professions, the clergy has to beware of becoming enculturated and defining its reason for acting in accord with what is considered socially functional.

The secularity of our society and its industrialization which allows men to believe what they will so long as they are "useful" in their jobs has affected the church and clergy in a way already previously alluded to. The theologian Jurgen Moltmann describes this development as follows: ²

By giving free rein to religion and leaving it to the free unfolding of the personality in complete freedom of religious choice, modern society as a "society of needs" emancipates itself from religious needs. . . . The Church thus slipped over into the modern *cultus privatus* and produced in theology and pastoral care a corresponding self-consciousness as a haven of intimacy and guardian of personality for a race that had developed a materialist society and felt itself not at home there.

Just as it is insufficient to be attracted to the psychotherapist because he may offer something mysterious, so it is naïve to approach the ordained minister in the expectation that he will serve primarily to satisfy

I doubt that a highly trained psychotherapist is using his time and energies in the wisest way possible if he chooses to aid the clergy by teaching a course in mental illness.

some human need simply because he is a clergyman. As a Christian, the clergyman sees his life in the light of service and will therefore work to minister to men's needs. But as an ordained minister, he is concerned for the salvation of souls and the continued faithfulness of a community. He is concerned that those he leads also understand their lives in the light of service. As Moltmann writes: ³

. . . the decisive question for Christian existence is not whether and how man in the fluctuating variety of his social commitments . . . can be "himself" and can maintain his own identity and continuity with himself. The point of reference of his expressions and renunciations, his activities and sufferings, is not a transcendental Ego upon which he could and must repeatedly reflect in the midst of all his distractions. But the point of reference is his call. It is to this, and not to himself, that he seeks to live.

There are a few suggestions which I would like to make in regard to future developments in the relationship between clergymen and the mental health movement.

During the next year some 2,500 seminarians will be involved in what is known as clinical pastoral education. These seminarians will be working in health and welfare institutions. Students will be required to do reading in psychology; they will be required to give verbatim reports of interviews with patients, and they will be taught to deal with emotional problems. But probably the most important aspect of this experience will be that it requires students to theologize in real-life situations. I think that it is crucial that supervisors of such programs place more emphasis on this aspect of the program in order that students become more aware of who they are.

The second suggestion has to do with education within the seminary itself. There seem to be many students who wish to make a clear distinction between their field education experiences and the classroom. This is unfortunate, for it means that the latter becomes a place for esoteric conversation, divorced from the realities of the secular world. The ideal is, of course, to integrate the two, and this can be done if on the one hand field education is education to be a clergyman and not a member of one of the secular professions. And on the other hand, it can be done if classroom work emphasises the importance of having the gospel speak to the condition of modern man.

For psychotherapists I would suggest two things. First, be aware of the reformation now occurring in the church and the fact that the confusion over the identity of the clergyman may manifest itself in the form of clergyman being overly respectful of the psychotherapist's secular discipline. It will therefore be necessary to have some theo-

logical sophistication. Second, I doubt that a highly trained psychotherapist is using his time and energies in the wisest way possible if he chooses to aid the clergy by teaching a course in mental illness. This seems to be happening more and more in the name of community mental health. The limitation is that although information is transmitted in this manner, no skills are taught. The clergy already have a kind of natural method for dealing with emotional problems. It is what I would like to call a "personal" approach to crises situations. A clergyman in such instances will usually share the feelings of those who come to him with their problems. In a crisis situation, this empathetic reaction can have a definite healing effect. A psychotherapist can help the clergy develop this method and be able to diagnose those situations in which a referral is the appropriate course of action.

The role of the clergyman is indeed an unusual one in our society. Secular professions can usually justify their existence on the basis of their being socially functional. The clergy cannot and must not justify themselves in this manner. To them falls the task of constantly witnessing the ambiguous demand to love and the mysterious call to have faith that God, not man, is ultimately in charge. It remains to be seen whether this culture can ever accept that fact and this includes those from the culture who feel themselves called to become clergymen.

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Jacqueline Montgomery, Ph.D.

Raymond D. McBurney, M.D.

Problems and Pitfalls of Establishing an Operant Conditioning-Token Economy Program

*After a successful project with the mentally ill, Operant Conditioning-Token Economy programs were set up on four of eight * units in the new Mental Retardation Division at Camarillo State Hospital. Similarities in the two programs include group leaders and their groups, levels, group medication and accentuated attention to grooming and appropriate behaviors. Difficulties in both programs stem from breakdowns in communication and inappropriate personnel. This program has developed innovations in Behavior Modification. Baseline studies have been done and individual treatment programs developed for each resident.*

Most reports of Operant Conditioning-Token Economy programs describe individual projects utilizing one, or possibly two, units of screened patients, usually of homogeneous types. These units are quite richly staffed. Many are funded by grants or special appropriations and although they may qualify as pilot programs, they do, by their very natures, depart from reality when it comes to establishing similar programs in large state hospitals where funds and nursing staff are limited and it is not practical to accept only selected patients. Having set up eight Operant Conditioning-Token Economy programs at Camarillo State Hos-

pital, six of which are still functioning, we feel fairly well qualified to discuss techniques and problems which are indigenous to this type of therapy.

In visiting other programs of this type and in discussing techniques with those supervising the work, one receives the impression that a valuable therapeutic modality has been developed, placed in operation and the environment then modified to secure effective functioning. We have used the converse of this procedure and attribute our success to preparing the environment and then establishing the program.

In preparing the environment certain essential steps must be taken to insure success.

Dr. Montgomery is Acting Director of Clinical Training and Dr. McBurney is Program Director at Camarillo State Hospital, Box A, Camarillo, California 93010.

* Since this article was written, the program has spread to encompass eight of nine units in the Mental Retardation Division.

The administration must, of course, give complete approval. This should include the hospital's medical director and extend through the assistant superintendent of the division concerned. One must also have the complete cooperation of the supervisory nursing service. This program cannot function without the personnel to make it work. The staff must be appropriate. By this we mean individuals who wish to be involved, who are enthusiastic about and who accept the philosophy of this type of treatment. All others should be asked to request a transfer or should be moved without a request being made. With these environmental conditions being satisfactorily taken care of, success would seem to be assured but such is not the case. The problems have just begun. A history of our programs may help to illustrate some of these situations. Of course, intensive training of all staff to be involved in the procedures of Operant Conditioning-Token Economy is necessary. This is most effectively accomplished by the psychologist but requires scheduling by nursing service since all shifts must be reached.

We are all subject to the mechanics of a Token Economy, which is a structural manifestation of Operant Conditioning, under which we strive to influence our environ-

vating a patient to change. It permits the patient human dignity by giving him the right to make a choice and to select the action he prefers. Concomitantly, it forces him to live and grow with the consequences of his choice. Making a choice is an action. One action leads to another and before long people who have not moved for years begin to display a desire for improving their life situations and their own effectiveness in dealing with life. The token economy is a structured schedule of daily living which makes it possible to apply the principles of operant conditioning and positive reinforcement which are derived from and well established in the field of learning theory.

We began with a group of sixty chronic, regressed, hard-core schizophrenic males with whom all modalities of treatment had failed. All the above-mentioned conditions were fulfilled and all nursing personnel expressed their enthusiasm and desire to remain with the program. Although we mentioned earlier that six of our eight programs were still functioning, it must be said that our first program was absorbed into our third program incorporating 140 of the same type of male patients. The nursing staff was so enthusiastic about the effectiveness of the program that within two months of the start of the project, the unit

Assuming that one has extra-unit cooperation, the weakest link in the chain is unhappy unit personnel.

ment to our benefit. The basic principle of Operant Conditioning is that the individual learns by the consequences of his behavior. The Token Economy teaches patients to become responsible for their own behavior, to make choices and learn from the consequences, to be aware of the need for an exchange of service or contribution of effort for the goods or services received. The Token Economy is a method of moti-

was on a regular sequence of unselected, routine admissions, taking its turn in the regular hospital rotation.

It is the exception that proves the rule. Shortly after starting our first program we began a similar project on a female unit. In this instance, nursing service did not concur in weeding out inappropriate personnel and we were afflicted with one overtly hostile employee who expressed her dis-

likes and opinions of the program to staff and patients regularly. Another technician was untruthful, unreliable and a violator of all precepts of Operant Conditioning. This program limped along because of the efforts of the other employees until we opened the Mental Retardation Division, at which time the desirable and appropriate staff members were transferred to the new project. Six months after establishing our third economy the Medical Director of Camarillo State Hospital asked us to install similar programs in the newly established Mental Retardation Division, which was accepting 500 transfers from other state facilities. The criteria for entering patients were that they be sixteen years of age or over, ambulatory, toilet trained and able to take care of their own necessities. Shortly after taking the transfers, we found that "toilet-trained" and "taking care of their own necessities" were only relative terms. Thus Operant Conditioning-Token Economy procedures were established on four of the eight units of the Division and involved 250 of the 500 patients.

Certain structural elements have been common to all our programs. The unit population is divided into groups, the sizes depending on the number of nursing personnel available as leaders. Each group of patients has a leader and an alternate to cover on days off and during sickness. There is a similar leader and alternate on the P.M. shift. The group leaders are responsible for their groups throughout their shifts, taking care of grooming, medications, appointments, recreation and the residents' activities in general.

The unit is also divided into three levels, with the first evidence of this shown in the dormitories. Level C is the lowest and is furnished in Spartan character. Level B follows, less Spartan-like, and finally there is Level A with as gracious living as the hospital and interested relatives will pro-

vide. Privileges are few in C level, increase in B level and are quite numerous in A level. The separation into levels is also present in the dining room. C level residents go through the cafeteria line and have their food served on compartmented trays. B level residents also go through the food line but their meal is served on dishes on trays. A level, however, is seated at cloth covered tables and is served by the personnel of food service. The sexes also eat together at these tables.

We are aware that some of our patients, the mentally ill as well as the mentally retarded, are so regressed that at this time they are unable to master the rudiments of the token economy. To avoid unwarranted loss of privileges, these patients, although remaining in C level, are treated as a separate therapeutic group and lose no privileges. In time many of them progress to the point that they may be enrolled in the general program.

Group identification is encouraged and daily meetings of the group leaders and their residents are held, while once a week a unit meeting is called and is led by the psychologist or a member of the staff.

Posted on the wall in all units are the list of criteria for the various levels, the daily schedule, a list of tasks available and their pay rates, the reinforcement scale and a list of costs and charges.

As our present activities are centered in the Mental Retardation Division, the rest of this discussion will deal chiefly with techniques and problems of the program in this area and the modifications necessary to fit it to the retardates. As contrasted with the mentally ill, most of whom have developed their psychoses after several years of learning procedures, the mentally retarded, without proper training, lack acceptable behaviors, social graces and the simpler skills. Misplaced sympathy and permissiveness may have enhanced the be-

havior problems. The attention and memory spans are much shortened. So many small things we take as a matter of course are entirely foreign to the retardates' behavior patterns. Our Operant-Conditioning routine does divide the residents into levels. Movement from level to level, however, may be more rapid and for shorter periods of time, and promotions to a higher level may at times be made without all the requirements having been fulfilled, as we have found that this may instill that sense of pride which will give the results we desire. Group nursing procedures are stressed and questions and problems are referred first to the nursing group leader who may confer with any one he wishes if necessary.

We emphasize positive reinforcement, preferring to reinforce incompatible behavior rather than punish inappropriate behaviors and using extinction to eliminate undesirable modes of response. One must

the height of their abilities. I.Q.'s are, for the most part, ignored. Our goal is to aim for the residents' highest potentials. I.Q.'s may be low but appropriate behaviors can be taught and learned. Self reliance, responsibility for personal hygiene and grooming, proper dining room behavior and social competency are the fundamental skills we aim to instill.

The actual mechanics of Operant Conditioning-Token Economy programs are simple and can be modified and tailored to suit any contingency. The techniques of Behavior Modification have been extensively covered in the literature.

However, during the development of the token economies a simple, clear, concise and very brief manual was written to teach the procedures of establishing and operating token economies for use by nursing technicians and other staff personnel concerned with functioning in such a program. A 16 mm sound and color film was made to document the daily life of the token economy and to demonstrate the principles and procedures of operant conditioning and positive reinforcement.

It would seem well to discuss the reasons for the failures, daily problems met with and procedures we have followed to avoid these pitfalls. Human nature being what it is and pay scales in different classifications not varying according to the amount of work done, a program involving a static population in contrast to an active admitting unit creates antipathy among the medical staff. This possibility was alleviated in our program by soon receiving regular admissions in our treatment of the mentally ill. With the retardates this has not been a problem as it is a separate and distinct area. As mentioned earlier, complete cooperation from the administration and nursing service has been present.

In addition, Food Service supported and extended the scope of the token economies

Human nature being what it is and pay scales in different classifications not varying according to the amount of work done, a program involving a static population in contrast to an active admitting unit creates antipathy among the medical staff.

always be on guard to avoid a punitive approach. At Camarillo State Hospital we have no locked seclusion rooms, no restraint and the nursing personnel must be constantly alert to early signs of trouble that will enable them to alter the environment so that small problems do not become major disturbances.

The group leaders stress good grooming and proper dining room decorum. All residents are involved in a communal house-keeping program, school, details, etc., to

Unfortunately, the doctor is seldom mentioned in articles relating to operant conditioning, as it has been developed chiefly by psychologists.

by participating in the original training sessions, developing the dining room procedures to a high level of efficiency and by making possible the appropriate dining arrangements for the different living levels. They use the token economy residents for details in the dining rooms and provide colorful uniforms which give status and special incentive for those working there. They utilize Work Evaluation Slips to assess the resident's contribution. Work and school and off unit activities or therapies return evaluation slips to the resident who brings them to his group nursing leader, who reinforces him according to the effort and productivity he demonstrated in the activity. These details and services participating in the token economies in this extended fashion have found that they materially increase the effectiveness of their interaction with the token economy resident. They also serve as a measure of the resident's improvement or growth. When he can go from an evaluation of "Poor" most of the time to "Good" most of the time it is evident that some advantageous change has taken place.

The administration did not have to be convinced, since the value of the program had already been evidenced with the mentally ill and its establishment in the Mental Retardation Division was at the request of the administration. Any doubters in the nursing or food services have been converted. In fact, the general attitude of the hospital has changed from amused tolerance to interest. This being so, the source of most problems is therefore concentrated in the team.

Unfortunately, the doctor is seldom mentioned in articles relating to Operant Conditioning, as it has been developed chiefly by psychologists. A disinterested unit physician can be a detriment to this type of program. Our first recommendation for establishing a program would be to assure ourselves of enthusiastic medical cooperation. Failing that, the next best situation would be the disinterested unit doctor who would keep a "hands-off" policy and allow the psychologist full sway.

At Camarillo State Hospital there are now two * physicians involved, each having charge of one male and one female unit. Each is enthusiastic about the program and in addition to being the titular head of the unit, is very active in the Operant Conditioning-Token Economy program. The overall program is set up by the supervising psychologist. It is supervised by her and individual treatment plans are set up and special behavior modifications are outlined. Baseline studies are also correlated by the psychologist. Each unit has a team—the physician, psychologist, all nursing personnel and the social worker. As interest has developed, others have joined the once-a-week, change-of-shift team meeting. This includes the rehabilitation therapist, occasionally the chaplain and others who have some specific interest.

The unit charge is extremely important. To carry through a program such as this, the charge must be an administrator, organizer, driver and have the confidence of his or her staff. The charge must program the day for the group leaders, schedule group meetings, unit meetings, behavior modification groups and all phases of the unit program. A strong P.M. lead is advisable, but a strong charge can compensate for weakness in this area. A strong charge will sense unhappiness, dissension and

* This number has grown to five.

breaks in morale and will take necessary measures to correct them. Unhappy or dissident nursing personnel must be moved or the whole program is threatened.

A.M. and P.M. shifts must meet each day. A.M. and P.M. leaders must confer daily and consider procedures for their groups. Compromises must be reached in differences of opinions and when an impasse occurs, the question should be settled by the team. All members must agree to abide by team decisions. Assuming that one has extra-unit cooperation, the weakest link in the chain is unhappy unit personnel. Such weak points may be very obscure at times and only by diligent attention and investigation can they be ferreted out.

At Camarillo State Hospital we have developed what we consider an innovation in our approach to behavior modification in our retardates. Nursing staff is limited and in order to utilize their abilities to the utmost we approached our behavior modification plans in an unusual way. Following routine time studies we found that there tend to be certain recurring patterns of behavior. By grouping the residents according to the type of behavior to be modified one group leader may use the same techniques for several at a time. The charge schedules these groups daily so this important phase of our program is fitted into what has already seemed to be a full day. The whole unit population can in this way be involved in therapeutic procedures.

The nursing personnel work harder in the token units than in any other area of the hospital but they do not complain, as

they are members of the therapeutic team and relate directly to the residents. They have an opportunity to use their professional skills to the utmost in a highly creative and rewarding manner. Given cooperation in all areas and with harmony and communication on the unit, the program is most unlikely to fail.

The first year was spent in the establishment of the token economies. Nursing staff were forced to concentrate on the development of the training procedures. Currently, baseline studies, individual treatment plans and group behavior modification plans have been made for every resident on two token economies and are in the process for two other economies. Social competency scales have been filled out for all residents of the mental retardation division and will be compared to those done six months and one year later. Token economies will be compared with units utilizing more traditional treatments. Placements might be compared, but this measure is not too valid since it depends upon the cooperation and permission of the relatives rather than just the readiness of the resident.

The token economy has proved to be a most stimulating and rewarding experience for all concerned. Hurdles have been overcome, training of both residents and staff has taken place and we have all grown in the process. Where the environment can be controlled, behavior can be controlled and a token economy is a highly efficient way of accomplishing the training of many by a few.

Reaching the Deaf: Report of an In-Hospital Group

The author discusses the formation of a group of deaf psychiatric hospital patients. Using sign language, members planned many activities. Such groups are seen as a way of bringing out patients who are unable to participate in the regular "talking" type of group.

Introduction

In a large metropolitan state mental hospital, no organized program was available for deaf patients. It was felt that providing a group setting would not only facilitate re-socialization, but would make both hospital facilities and community resources available to otherwise dormant, presumably uncommunicative patients.

The group was intended as a re-motivation and socialization outlet for deaf patients, who, otherwise, would have difficulty communicating with those of normal hearing around them. It was hoped that the company of other patients would lead to renewed interest in themselves, others around them, and ultimately to interests beyond the hospital setting. The group functioned for approximately one year.

Approximately fifty patients were screened. The only prerequisite for placement in the group was sufficient response to rudimentary finger spelling or use of sign language, and a willingness to participate. Many of the patients referred were not actually deaf, although they appeared to be unable or unwilling (so severely withdrawn) to communicate.

We found seven patients who were able to communicate and willing to participate. One that had been overlooked at the initial screening was discovered later, and added. One was dropped, one became physically ill and had to drop out temporarily, and one "dropped" herself. Perhaps a look at each member individually might give some hints as to how each was and is, and how they have related to one another.

The Group

MR. B was a forty-five year old single male patient. He had been in the hospital for five years, had been in another hospital for three years prior to his present admission, and was diagnosed Chronic Brain

At the time this article was written, Mr. Geller was Administrator of Professional Services for Specialized Services, Inc. He is now Executive Assistant for Program Planning with the St. Louis Jewish Employment and Vocational Service, 1727 Locust St., St. Louis, Mo. 63103.

Syndrome due to trauma with psychosis. At first it was necessary to coax him to come to meetings by offering him cigarettes. He had difficulty communicating with the group, since he would not use or attempt to learn the use of signs, although he was an excellent lip reader. At times it seemed as though he understood more than he would acknowledge, and usually his contact with others was to ask for cigarettes (despite having money of his own), to make a complaint, or to want to go to the canteen, to get coffee. He became progressively more restless as the group began to become better acquainted with each other and as they began limiting him on the requests for cigarettes. He could relate (superficially) much better to hearing people, because he was thought to be "cute" by his quips and ways of begging cigarettes. In the group he was treated like just another member, entitled to no special status, and less and less attention was paid to him (his begging or demanding was limited or he was essentially ignored).

He began leaving the meetings under the pretext of going to the bathroom or to get a drink and he would wander the halls and offices, begging for cigarettes and coffee. He would refuse to leave unless he was given coffee. This progressed to the point where it was disruptive to the group. He had to be hunted regularly by staff, and ultimately it was necessary to drop him from the group. He also refused to participate in planned group activities.

MR. S was a seventy-eight year old, widowed male patient. He was working as a presser in a cleaning company, married, and doing well until he was about forty-seven years of age. He was injured resulting from being struck by a bus. He had a head and leg injury. He was unable to continue working, became depressed, felt he was no good to his family, and threatened suicide.

He became more despondent, could not eat, statements made to the wife were bizarre, and he was hospitalized. Original diagnosis was Situational Neurosis.

He was an active participant in the group. He was almost the authority on sign language, and was well-liked by all members. Prior to his coming to the group meetings, the hall staff had indicated he had at times been belligerent, and had a few periodic "outbursts", but that this did not seem to be noted at any time following his participation in the group. He was always dressed and ready, and looked forward to group meetings and planned trips.

MRS. P was a fifty-three year old married female patient. She was first hospitalized at age thirty-nine for combativeness and bizarre behavior in the home. The difficulty began seven years earlier when she had an accident in which her leg was severely broken. She felt this was a "deformity". There were some marital problems at that time. She had a lobotomy several years later, and was discharged as improved. After seven years she was readmitted for bizarre behavior and diagnosis was Schizophrenic Reaction, Chronic Undifferentiated Type. She had been on a closed hall, and had not wanted to leave the hall and wanted to return to it when the group session was in progress, saying her husband might come to take her on pass. According to the staff on the hall the daughter or son-in-law picked her up for a one day pass about once every other week.

In the group she seemed to undergo somewhat of a regression. Initially, she would respond to others if asked a question, or state her husband was coming to pick her up, or stare straight ahead. Hall personnel would take her for walks and drop her off at the meetings. She became hostile about attendance, in a passive-aggressive way. That is, she did go with the group on sev-

eral trips to local points of interest, but tired quickly, and insisted she be returned to the hospital. This made it necessary for the group to return early, before the trips

herent, appropriate, and at no time had displayed what could be considered psychotic symptoms.

MR. T was a fifty-three year old single

Part of rehospitalization was considered due to her parents' difficulty with communication and understanding her needs.

were completed. The group did show some dissatisfaction, but did not seem to carry this beyond some grumbling while on the trip. It was after the second trip that she refused to come to meetings. She was told that she could rejoin the group at any time, and she was dropped from the group.

MRS. G was a fifty-two year old, widowed, female patient. She was first hospitalized at age thirty-four, following a suicide attempt and some paranoid-like symptoms. She was separated from her husband, and despondent about not being able to provide adequately financially for her four children. She apparently barely survived, and tried peddling in the streets. Nine years after admission she was placed on trial visit improved, and brought back about twelve months later by her father. She displayed temper tantrums at home, and was otherwise isolated. Her parents were not deaf. Part of rehospitalization was considered due to her parents' difficulty with communication and understanding her needs.

Initially, in the group, she seemed much more serious, or preoccupied, and would only communicate with another group member, Mr. T, her "boy friend". Gradually, she seemed to communicate more, and was working in one of the hospital industries. She later smiled and laughed, and was an active participant in the group. She and Mr. T were often together in the hospital canteen or walking and holding hands in the halls. She became quite co-

male patient. His first hospitalization occurred at age seven through the Juvenile Court because of his inability to communicate, and due to parental neglect. His diagnosis was mental deficiency. It was recommended that he be placed in a habilitative agency for the deaf almost immediately. Mr. T. spent most of his life between the hospital and the state training school.

He was working in hospital industry, was the best oriented member of the group, had some hearing, and was an excellent lip reader.

He was definitely a leader of the group, was in good contact, and displayed no psychotic symptoms. He was quite supportive to other patients, would treat them to cigarettes and coffee when he could, and always lent a hand, for example, with Mr. S's wheelchair. It would seem that Mr. T., especially if steps had been taken earlier, could have fit quite adequately into the normal deaf community.

MRS. S was a fifty-eight year old, divorced, female patient. She was first hospitalized at age twenty-seven, and her statements about her husband seemed delusional, but this was later questioned, and release was recommended. She was released several months later and returned under the same conditions as her previous admission (which were vague). Five years later she was released, and returned again one year later. Her diagnosis was Catatonic Schizophrenia.

Mrs. S. came to the group unexpectedly, as she was not on the original list of referrals from the sections. Mrs. G. brought her, and she was accepted by the group. She was passive, and usually was quite "serious" in terms of facial expression, and usually responded quite appropriately, if and when the conversation was directed at her. She was appropriate, and actively participated, especially when trips outside the hospital were planned.

MRS. S was a seventy-two year old, divorced, female patient. She was first admitted at age forty-two. She had seemed to have difficulty following her divorce, and this was eventually in the form of suspiciousness, and she became, over a four-year period, hallucinated and delusional. Diagnosis was Paranoid Schizophrenia. Initially she was quite reluctant to come to the group.

During the course of the group meetings, she had a physical illness which prevented her from attending. Following this she went through a period of not wanting to come. She later agreed to come, signing fast and furiously several times all about her illness, her old age, how she felt good now, etc. She and Mr. S. seemed to exchange a bit of conversation comparing health and age. Since her return was very recent, and she had not taken any of the trips with the group, it was difficult to make any evaluation, especially in lieu of the turn about in her behavior. She looked forward to, and was an active participant at the meetings.

MISS F was a twenty-three year old, single female patient. Her first hospitalization was at age twenty-two because she was "running away and becoming belligerent." At times her behavior was unpredictable, and her parents had difficulty coping with her. The diagnosis was Mental Deficiency with Psychotic Reaction.

She seemed interested in the group and indicated that she felt self-conscious about being overweight, which was her reason for not participating in group activities. Finally she agreed to go with the group on a tour of a local small-scale zoo and animal reserve. She seemed to enjoy it.

It is felt considerable progress was made with Miss F., as she was initially withdrawn. She even volunteered for a weight reducing program. She has recently been discharged at home on trial visit and enrolled in school.

Observation and Evaluation

The main topic in the group was planning for out-of-hospital trips. A blackboard was helpful when staff or patient had difficulty being understood, as well as to list suggestions or vote on places to go. Sometimes the staff was all but excluded, as patients seemed to take over, with discussion about places to go, (i.e., that one member had seen before and wanted to encourage the others to request), or just conversation about passes, health, or what might be termed "small talk."

If the initial goals are kept in mind the following accomplishments can be put in perspective. Referral to agencies (Mr. T's test for hearing aid evaluation, and contact regarding Mrs. G's previous rehabilitation

The deaf do, as a whole, seem to be both very candid and straightforward. Even their language is expressed in terms of actions (by sweeping arm, hand and finger movements). They do not seem to respond to the more usual "talking" type of group.

program and present status), contact with the deaf community (regular monthly trips and social get-togethers with a church-sponsored, non-sectarian deaf group in the city), use of hospital facilities (industrial therapy referrals, referral for educational therapy for Miss F., and referral of Mr. T. to vocational rehabilitation), and socialization (group meetings, trips planned solely by the group, and group participation in all other areas mentioned) were in process.

The original co-therapist in this group was a chaplain intern, who contacted a deaf church in the community, which was most receptive to including the hospital group on picnics, field trips to local points of interest, and church functions. The patients found themselves easily accepted, were quite appropriate, and some met old friends they had not seen in many years. This participation tended to set a more appropriate pace for the group and turned attention or focus of some group members on longing to be out of the hospital, rather than being fearful of what might be "out there". Despite age, diagnostic, and other differences, the group became regular, and, quite "homogeneous" in its support for individual members, tolerant (i.e., willingness

to accept Mr. B., but on the group's terms), and displayed ability to plan together.

It must again be noted that the focus of the group had been planning for future trips as well as just talking as any social group or get together might be. This is considered appropriate for several reasons. First, it gives an outside the hospital activity as something to look forward to. Secondly it is action oriented. That is, although generalizations have decided drawbacks, the deaf do, as a whole, seem to be both very candid, and straight-forward. Even their language is expressed in terms of actions (by sweeping arm, hand, and finger movements). They do not seem to respond to the more usual "talking" type of group. This approach seems to have been beneficial from all standpoints in terms of original goals, and might be a basis for other groups in institutions which have little or nothing to offer the deaf. A few lessons in finger spelling, and a few rudimentary signs, and some determination and interest on the part of a staff member, could mean the difference between staring and caring for many isolated deaf patients who are unable to communicate with those around them.

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Social intervention—consultation to organizations

This paper attempts to clarify seven different consultation models and four phases common to each of them. Two cases involving consultation to organizations are discussed utilizing the above mentioned principles. One case describes consultation to a suburban school system, the other cites an example of consultation to a neighborhood health center located in a ghetto section of a midwestern city.

Models

Mental health consultation which, of late, has been achieving increased prominence and attention, is seen as "a helping process, an educational process, and a growth process achieved through interpersonal relationships."⁵ In a recent paper, Bindman¹ describes seven different consultation models. Briefly, they are as follows.

1. **The medical consultant model**—one professional requests another professional as an "expert" to interview or evaluate the former's client in order to make some recommendations for problem resolution.

2. **The resource consultant model**—a consultant from another agency or discipline discusses specific issues or assists in planning new program development.

Dr. Rosenblum is a regional mental health Administrator for the Massachusetts Department of Mental Health, Room 210, 888 Washington Street, Dedham, Mass. 02026.

This article is based on a presentation made before the American Psychological Association Convention in San Francisco in September 1968.

3. **The intramural administrative consultant model**—a consultant who holds an administrative position in an organization provides consultation to personnel within the same organization.

4. **The counselor consultant model**—a consultant becomes involved in a counseling relationship with a consultee whom he views as the client. This model intrudes more directly than the others into the realm of psychotherapy.

5. **The mental health consultant model**—a consultant meets regularly with a consultee with the specific goal of enabling the consultee to solve mental health problems himself, which he encounters in his professional capacity, in order that he might be able to handle similar problems in the future more competently. This model is most closely related to the works of Caplan, Lindemann and Klein.

6. **The consultant—trainer model**—a consultant meets regularly with a group of consultees to discuss problems that the consultees face in their professional functioning. The method employed is a case seminar approach in which a group member presents case material for discussion by the group. The consultant acts variously as a group leader, teacher, clinician, and facilitator of communication among members of the group.

7. The change-agent model—a consultant meets with key care-givers in the community or key professionals in agencies and institutions in order to bring about changes in the organizational structure or social system. The intervention may be active and politically oriented or may be catalytic and politically neutral. This approach encompasses such concepts as "planned change", "the helping relationship", "sensitivity training," and group dynamics theory.

Irrespective of the consultation model there are certain common sequences which occur in every consultation effort. Gibb² describes them as follows:

1. Entry—its form and nature predetermine certain consequences in the ensuing relationship;

2. Diagnosis—this involves an examination of the motives of the consultant and consultee, a definition of the problem, and an assessment of the magnitude of resistance to the proposed change;

3. Data collection—the kinds of data sought and the methods of gathering them will be determined by the aims and goals of the consultant;

4. Relationship—a mutual acceptance and respect for the other's integrity is the *sine qua non* of a successful consultation outcome;

5. Boundary definition—agreements about the limits and roles taken in the relationship must be established at the outset by the two parties;

6. Resource development—this includes the ways in which the consultant can be a resource and the nature of the development of this role;

7. Decision making—how decisions will be made will vitally affect the outcome of the consultation process;

8. Termination—relationships are altered gradually during the consultation relationship so that termination may occur without undue disruption to the social system.

The consultation process can thus be seen as consisting of four phases:

★ The preparatory phase—appraisal of the situation;

★ The beginning phase—development of the relationship with the consultee(s);

★ The problem-solving phase—discussion of the major issues of the consultation;

★ The termination phase—resolution of the consultation issues.

Case Studies

The remaining portion of this paper will focus on two case studies of consultation to organizations. One approach to an analysis of a case study is for the consultant to formulate a number of recurrent questions which he must work on during the course of the consulting relationship. This approach will be utilized in discussing the first case which describes a consultation undertaking to a public school system in an affluent suburb of a large metropolis in the Northeast.

Question No. 1

What is the reason for the consultation request? What is the source of trouble?

This school system was ambivalent in its initial request for regularly scheduled consultation. This town has a strong pro-Birchite element which attributes anything as "radical" as mental health consultation as smacking of socialistic or Communistic tactics to subvert the youth of America. Countering this trend were a group of ministers, the guidance counselors at the school, and some League of Women Voter parents who felt that the school system would benefit from the introduction of a consultant into the schools. The superintendent finally agreed to permit this arrangement as long as he was not personally involved and as long as no serious repercussions ensued from the community. The consultant decided to move at a pace which would be acceptable to the school system; at the same time he had to try to effect some eventual changes within parts of the system if he were to accomplish his desired goals.

Question No. 2

What preliminary steps of action are needed to establish the consulting relationship?

The consultant met first with the superintendent of schools to spell out in detail what he wished to do and how he proposed to go about doing it. He attempted to reassure the superintendent that he would constantly apprise a selected school representative of his planned meetings, seminars, and consulting schedules. In turn, he asked permission of the superintendent to visit the principals, teachers, and guidance personnel of the various schools to define his role, ascertain their needs, and plan his schedule. The superintendent granted this request (although he showed up unannounced at the first school which the consultant visited in order to hear, in person, what the consultant was telling his subordinates). The further steps of initiating case consultation with the various schools, establishing discussion groups, and effecting a relationship with the consulting school psychiatrist and the superintendent's representative required considerable time and skill on the part of the consultant. Not only did he attempt to offer diagnostic help and suggestions for change but he also had to assist those who sought his help in the actual working through of the change process.

Question No. 3

What are the forces working toward change and those resisting change? What are the major issues to be solved?

In this school system the major issues requiring change included a minimal awareness on the part of school personnel (at all levels) of the mental health implications of the educational process, a lack of effective communication between parts of the system, too diffuse distribution of power by administrative personnel, and a reluctance to make decisions or take appropriate actions for innovation because of fear of the consequences by vocal reactionary elements in the community.

The forces working for change included an influx of bright young teachers entering the school system who had new ideas and the enthusiasm to carry them out, some principals and guidance personnel who were frustrated by the obstacles constantly being imposed upon them, and segments of the community who were demanding an upgrading of the concepts and implementation of the education process. The main factor resisting change included the con-

servatism inbred for generations in this community and the fear and distrust of new ideas.

Question No. 4

How does the consultant promote and/or guide the process of change?

Lippitt et al.⁸ suggest several stages in the process of working through problems of change. Some of them are applicable to this case. These include: (1) The establishment of the consulting relationship; (2) The examination of a range of suitable solutions and goals; (3) The transformation of intentions into actual change efforts; and (4) The stabilization of a new level of functioning.

Space does not permit a detailed discussion of the change process in this school system. Briefly, an attempt was made by the consultant to meet the needs of the system as they were presented; gradually the case consultation approach was modified to include some administrative consultation as well whereby new policies could be formulated and new approaches attempted. After three and one-half years of consultation, only part of the consultant's goals had been realized. While notable progress was made in facilitating the process of communication between teachers and principals, in providing increased awareness of mental health principles in education, in aiding some teaching and guidance personnel in the establishment of specialized programs, and in helping them to be more effective in their professional relationships, much still remains to be done. Administrative consultation has not been possible with the Superintendent or the Director of Guidance. The consultant left to take on a new job and his successor met with considerable initial resistance. Nevertheless, the new consultant feels optimistic that he will be able to further the change process.

Question No. 5

What are the goals of the consultation process?

To be successful, consultation with an organization should end with at least three kinds of learning. The organization should have learned to cope more adequately with the problems which initiated the consulting process; it should

have learned how to handle future problems or be able to seek help with these problems, if necessary; and it should have learned new procedures and new types of organization to enable it to be flexible enough to adapt to changing conditions and to new approaches to problem-solving.

In this case study, it is evident that the goals have been only partially realized. An analysis of this organization provides us with an understanding of the consultation process more by its limitations in the efforts toward planned change than by its successes.

The second case study describes an attempt by the author to assist a neighborhood health center in a ghetto area of a midwestern city to diagnose its organizational problems and breakdowns in management-supervisor interpersonal relations. The goal of this consultation endeavor was to suggest changes in the organizational structure, in the perception of the work problem, and in the communication process among the members of the organization.

Shortly after it became operational, this health center began to experience internal difficulties among its staff. During the consultation process, it became apparent that these were due largely to a lack of clarity concerning the overall goals of the center, and to communication difficulties between its four program segments as well as between these units and the center's project director. Other difficulties which were detected included program isolation and competition among the four units, remote and haphazard supervision, and excessive distance between the policy makers and the implementers. To make matters worse, by the time consultation began, the head of one of the units had just been fired (but agreed to come back to meet with me during the three day consultation period) and the project director had just returned from an extended visit abroad (at a time when his presence was sorely needed at home).

Again, in this case the first step of the consultation process consisted of a diagnosis of the nature of the difficulties in the organization. This was accomplished by separate meetings

with all the key persons in the organization and listening (mostly) to their perceptions of the problem. Next, change possibilities were structured with the project director as well as with the unit chiefs. Specific changes were suggested and alternate opinions were solicited.

The third step consisted of efforts to translate these change intentions into operations. A training program was recommended on a continuing basis. This included in-service training, outside consultation, and participation of key staff in an intensive human relations laboratory experience. These recommendations are now in the process of implementation. In addition, the project director has instituted scheduled meetings with his chiefs in order to improve the communication process. He is permitting them more voice in the planning stages and more authority in the program implementation. More specific overall goals involving representatives of both the staff and the community are currently being reformulated.

The final step will involve a generalization and stabilization of change process. Arrangements have been made for the consultant to return in the next six to eight months to assess progress during this follow through period, and to assist in helping the center plan for systematic ways of adjusting to its changing needs in the future as well as to the changing needs of the community which it serves.

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C. R. Gilpin, M.D.

Edward Neufeld, M.S.W., A.C.S.W.

Community Cooperation and a Shoestring Budget: Rx for an Activity Therapy Program

Activity therapy programs are not new. However, to its professional and lay participants, the manner in which the Group Activities Program in East St. Louis came into being, and the character of its services, have been unique in many ways. The program was established with almost a total absence of a firm financial base. It was begun and has continued with a minimal amount of cost and has produced a maximum amount of meaningful community and patient participation.

The Need

In recent years the mental health and social welfare community in the East St. Louis, Illinois area has become increasingly aware of existing "gaps" in services to the mentally ill. As the concept of "Community Mental Health" and the idea of "treating the patient within the community" gained momentum, the readmission rate to the state hospital made it clear that many former hospital patients required additional follow-up care other than that provided at the outpatient clinic.

Early in 1967, a meeting was set up involving the Mental Health Center, the Illinois Department of Mental Health, Alton State Hospital and the Mental Health As-

sociation of St. Clair. It was decided to pursue the possibility of a pilot program, based on a day care and activity therapy approach.

The Response

By April, 1967, the community response had evolved into a functioning Group Activity Program. A local agency, The Lessie Bates Davis Neighborhood House, donated space for the program which was initially to be held weekly on Monday mornings. The Department of Mental Health, the Alton State Hospital, and the Mental Health Center donated professional personnel to guide in planning and operation. The Mental Health Association of St. Clair County provided an active group of four volunteers. A crash program of volunteer training was completed. The local newspaper carried stories about the program with a full page picture section. The entire community as a result, became interested, and community involvement was encouraged.

Dr. Gilpin is a psychiatrist who, at the time this article was written, was on loan to the Mental Health Center of St. Clair County from Zone VII of the Illinois Department of Mental Health. He is presently employed by the Mental Health Center of St. Clair County, 3939 State Street, East St. Louis, Ill. 62205. Mr. Neufeld is a psychiatric social worker at the Center. Both have been involved with the Group Activities Program since its inception.

Financing

Initially, the Board of Directors of the Mental Health Center designated \$200.00 to be used to purchase materials. As a result of speeches and individual contacts by enthusiastic volunteers, two local women's groups donated a total of \$75.50. Other groups and individuals offered on-going "in-kind" services such as donations of pastries, food and gifts for a Christmas party, cups, coffee and equipment. As the program grew, other agencies became involved, until at the time of this writing, numerous voluntary organizations, churches, clubs, and at least eight agencies were directly involved.

Workers included community volunteers, activity therapists, nurses, psychotherapists, social workers, student social workers, secretarial help and social work assistants from such agencies as the Mental Health Association, Alton State Hospital, the State Department of Mental Health, the Mental Health Center, the "New Careers" Program, the Neighborhood Opportunity Center, Neighborhood Youth Corps and the Department of Public Health.

equipment (i.e., record player, movie projector equipment), cost of regular field trips, and so on. Also, there were sufficient funds remaining to hire a part time staff member. A former volunteer, this person was hired as a coordinator to give continuity to the program (as there are numerous staff changes from day to day). She also acts as a purchasing agent, coordinates craft projects, integrates activities of other volunteers and so on.

Program Outline and Philosophy

The program operated on a pilot basis one half day a week for a period of two years. Since the spring of 1969, following the county funding, it has expanded to three mornings per week. It is designed to be a joint venture of community volunteers and professional staff. A typical morning began, initially, with light calisthenics (to music), followed by simple folk games and square dancing. After a brunch of coffee and pastry, the remainder of the morning was spent working on crafts or projects, playing table games, participating in basketball or other gymnasium games (by

One year after the beginning of the program, there was nearly \$50.00 remaining of the \$275.50 cash allocated since the program began.

One year after the beginning of the program, there was nearly \$50.00 remaining of the \$275.00 cash allocated since the program began. Donations of food and supplies accounted for \$300.00 more, with bought supplies taking up the cash allocations. Professional services and physical space do not come under this budget breakdown.

Following a successful St. Clair County mental health referendum this program was funded with a first year grant of \$5208.00 beginning in the spring of 1969. This provided for expansion to three mornings per week, rental of space, purchase of

the younger and more active patients), and general "socializing". Since expanding to three mornings per week, additional therapy programs have been added. There are regularly scheduled "talk groups" led by professional persons. There is a women's sewing class. There are semi-educational programs (i.e., "current events"). Visual aids, such as regularly scheduled movies are utilized. A woodworking shop is available, and a men's woodworking class is being organized.

Patients are referred to the Group Activity Program through the Mental Health

Center, where intake and screening of the patients, with respect to their needs is conducted. The primary referral source is the Alton State Hospital, whose discharged patients are all considered for the re-socialization which Group Activities affords. The Illinois Department of Public Aid has referred patients to the Mental Health Clinic specifically for consideration for Group Activities. A local nursing home for chronically ill patients has a number of patients involved in the program. In general, all of the patients who come to the clinic for therapy, and for whom Group Activity experience is recommended, are eligible for the program.

The therapeutic effects of the program became evident from the beginning. Chronically and severely ill patients began involving themselves more verbally and appropriately in their therapy hours in the clinic. Observable changes in dress, manner and attitude occurred.

The program has operated as a "therapeutic community", in which distinctions between the helper and the helped are minimized. A number of patients in the program have evolved into very successful volunteers. The program was deliberately geared to be greatly supportive and giving (i.e., the coffee and donuts) along with providing built-in opportunities for patients to move toward less narcissistic and more mature experiences. With the thought that giving is therapeutic to the giver, special effort was made to build a service function into the activity program. For example, at Christmas time the patients are encouraged to help make gifts for the children who attended daily programs at the Neighborhood House. The response from the patients has been quite positive. There has been a personal presentation of over ninety gifts to the director of the Neighborhood House each year. Without exception, the donors of the gifts verbally express their personal

satisfaction at being able to "give" and help others.

A most interesting aspect of the Group Activities Program has been its flexibility in accepting participants and in the therapy milieu offered them. The program has, at times, been used successfully as an alternative to hospitalization for acutely ill and severely depressed patients. It has speeded up therapy for many clinic patients, who, though perhaps not seriously ill, may have had difficulty relating to others. It has served as a treatment resource for adolescents as well as adults.

In addition, mentally retarded patients have been referred to the program. At this time there are a number of adolescent and adult retarded patients who have made noticeable gains in impulse control and educational achievements, through this program. It is a constant source of fascination to watch a new patient become incorporated into the activity group. A young patient may enter the program a bit fearfully in the beginning, the preponderance of older adults being rather overwhelming. Within a few sessions the "family" atmosphere prevails. The patient becomes the responsibility of the other members. When he "acts out" he is gently chided. When he does something well (i.e., a craft project) his work is displayed and he is praised while the others beam with pride at his accomplishments.

The overall Group Activities Program has expanded to include limited educational and work training. A number of the women have successfully joined a sewing class at the Neighborhood House and a number of men are learning the skill of cane weaving chair seats.

Empirical Results

Although specific statistical evidence of the effects of any therapy is difficult to ob-

tain, some self evaluation was built into the program. Attendance statistics indicate that participation has been quite regular with an average attendance of twenty-five patients. There has been a gradual increase in average number of patients as the program progressed. The majority of participants were also involved in individual or group therapy at the Mental Health Center, concurrent with their enrollment in the Group Activity Program.

The first formal evaluation of the program was conducted after nearly a year of operation. In the period from April, 1967 to February, 1968, service was given to a total of 91 different patients. Therapists at the Mental Health Center were asked to rate the progress of those of their patients who were involved in the activity program.

They found that 44, or 48.4%, had improved, 12, or 13.2%, remained the same and 1, or 1.1% became worse. There were 34 patients for whom progress could not be recorded. This included five who had just been admitted to the program and fourteen on whom evaluations were not obtainable due to premature terminations or other reasons not known. Also included are fifteen patients who enrolled only in the Group Activity Program and not in therapy at the Mental Health Center of St. Clair County. Most of this latter group are reported to be doing well.

A second evaluation was conducted in the spring of 1969 after three years of operation. The evaluation covers the period, April 1, 1968 to April 30, 1969. During this time a total of 112 different patients were served. Of these, a total of eight (8) were rehospitalized or approximately 7%. This is in contrast to an overall State Hospital rehospitalization rate which in the past, has approached 80%! Personnel at the State Hospital consider this program to be a significant factor in the reduction of the number of rehospitalized patients.

Indirect Expansion

A number of Neighborhood Opportunity Center Coordinators who operate under the local office of Economic Opportunity Commission have accepted invitations to observe the group activity program. These groups and other community groups are presently firming up plans to begin their own programs patterned after the Group Activities profile. A neighboring Mental Health Center has begun a program in its area. Observers from Mental Health groups in an adjoining county utilized our experiences and have a similar program in operation.

Future Plans

In the area of expansion, the possibilities seem limitless. Thus far, the program has often been internally expanded by the volunteers and the patients themselves. As an example, an enthusiastic "weight watchers club" was begun through a suggestion by a patient. Their suggestions may well open the door to many other avenues that are not anticipated at this time. It would seem a natural outgrowth for a portion of the program to move to a seven day per week "day hospital", complete with medical, nursing, and total psychiatric care. Such a service is needed in the community. This service could be combined with "night hospitalization."

The "work training" aspect of the program could be expanded to include a sheltered workshop and industrial therapy. However, the work training needs are presently being adequately met through referral of patients who are sufficiently improved to Specialized Services of East St. Louis.

The workers involved believe that, whatever future plans entail, the present activities revolving around recreation and socialization in an informal unstructured environment, should remain as an integral part of the program.

Cameron R. Dightman, M.S.W.

Fees and Mental Health Services: Attitudes of the Professional

The author examines traditional attitudes toward fee charging held by mental health professionals. Results from a questionnaire indicate that psychiatrists, psychologists and social workers believe that for therapeutic purposes almost all persons should be charged for use of mental health services. While all believed, in varying degrees, that the best fee is one that fits into the client's budget, it is speculated that in agency practice professionals are not concerned about whether a fee is ever paid. The author discusses the impact of fee charging on the Community Mental Health Centers Act concept of comprehensive care for all citizens.

It is the purpose of this paper to examine, from the perspective of the mental health professional, the impact of fee schedules on mental health services. The history of fee charging for mental health services dates at least back to the days of Freud, the first of many to systematize the treatment of mental problems in a private, professional practice. It also includes the work of the voluntary social agencies as they moved from providing material assistance only to the provision of counseling and casework services. The development of fee charging in these two different situations was based on different considerations.

Within the frame of reference of private practice, Freud⁷ openly stated that the basic reason for charging fees was "self-preservation". Fromm-Reichman⁸ agreed that the market value of the service provided determined the size of the basic fee,

but saw no objection to seeing patients at a reduced fee when it was economically feasible. Recent psychotherapists have advocated adherence to a more rigorous fee system,^{10, 16, 17} suggesting that treatment will be less than maximally effective if the patient is not making a financial sacrifice. Implicit in this policy is the belief that it is essential for the patient to pay a fee whether or not the therapist is dependent on it for his income.

The voluntary social agencies began charging fees for services in the 1940s. The focal concerns in adopting a fee charging system, as reflected in the literature, were administrative considerations of fee charging,^{4, 18, 21} therapeutic values of fees,^{2, 14} and the reactions and attitudes of caseworkers and clients to fees.^{3, 11, 12} The two basic reasons for establishing fee charging policies by voluntary agencies were that: fee payment for those able to pay would be of therapeutic value to the client; and persons in need of services but who would not

The author is a research investigator with the Division of Research of the Department of Institutions, Olympia, Wash. 98501.

accept free services would be able to use them.^{5, 6} Though derived from a different system of treatment, the first of these two reasons is remarkably similar to the position of the private practitioners.

Review of the Literature

The first of several recent studies re-examining the impact of fee charging on mental health services was conducted by Goodman,⁹ who reviewed fee paying and non-fee paying cases in a family counseling agency. He found that there were significant differences in rates of beginning and continuing treatment between fee and non-fee payers. Unfortunately, the fee and non-fee groups were not randomly assigned, so the findings may be due to other factors, i.e., socio-economic status. In a partial replication of this study, Adams¹ found that fee and non-fee paying clients, while differing significantly in income and educational levels, did not differ in appointment keeping behavior, in assignment to brief or continuous service, or in the number of appointments made.

Lievano¹⁸ assessed the relationship between payment or non-payment of a standard fee in a psychiatric hospital outpatient service and found that benefit from treatment was unrelated to whether complete, partial, or no payment was made. The effect of fee vs. no-fee in a college counseling service was evaluated by Thompson and Handy,²² who found no differences between the two randomly assigned groups in the proportions of clients assigned tests, completing tests, or returning for the interpretation of tests. Other voices,^{13, 20} in examining the importance of fees, suggest that it is not the fee itself, but the professional's own attitude toward it, that determines whether or not fee charging is a necessary and/or useful adjunct to treatment.

The degree to which mental health services will actually be made available to per-

sons unable to pay for them depends to a large extent upon the attitudes that mental health professionals have toward fees, since in most mental health agencies, the professional participates in the decision about fee charging. If the professional believes that fees are most important because of their therapeutic value, no-fee service would probably not be offered. If, on the other hand, the professional believes that fees are most important because they are a source of agency income, no-fee services could be provided to the extent that they were economically feasible.

In view of the requirements of availability of service built into the Community Mental Health Centers Act, one must ask whether present professional attitudes towards fees are supportive of providing no-fee mental health services. If they are not, one must seek a fee policy that maximizes compliance with P.L. 88-164 and is also palatable to professionals.

Method

—*Subjects.* The sample consisted of the members of the faculty and field instruction staff of the School of Social Work at the University of Washington, the faculty and residents of the Psychiatry Department at the University of Washington, the membership of the Northwest Family Therapy Institute, and the members of the "panel of

Psychiatrists feel that agencies charging fees provide a different quality of services than do agencies not charging fees. . . .

therapists" of the Tacoma Community Mental Health Clinic. Because many persons belonged to more than one of these groups, the final sample consisted of 297 different individuals.

—*Procedure.* A questionnaire, consisting of five sections, was developed to obtain infor-

mation about respondents and their attitudes towards fees. This questionnaire, an introductory cover letter, and a stamped, addressed, return envelope were mailed to each of the 297 persons in the sample in October of 1967. The respondents were assured of anonymity, but invited to provide their name and address so that preliminary results could be shared with them.

In the first section of the questionnaire, information was requested regarding each respondent's sex, age, educational attainment, present occupation, degree of present involvement in providing direct treatment, and whether clients paid fees for these direct treatment services. The second section of the questionnaire contained 22 statements to which the respondent was to indicate (on a five-point scale) his degree of agreement or disagreement. The statements dealt with the interaction between socioeconomic level of clients and the importance of fee charging, the effects of fee schedules on appointment making and appointment keeping behavior, and the relationship between fee schedules and the quality of service provided.

In the third section of the questionnaire, respondents were requested to indicate the degree of desirability or undesirability of seven different methods (e.g., fees only, taxes only, fees, taxes and donations) of funding agencies from the point of view of providing maximum benefits to clients. In the next section of the questionnaire, respondents were requested to indicate the degree of importance which they attached to fee charging in the treatment of clients who had various kinds of problems. The fifth section of the questionnaire contained multiple choice questions dealing with the mechanics of a sliding fee schedule, the importance of fees in short-term treatment and, again, the best method of funding a mental health clinic.

Analysis of the data was planned so that

Mental health professionals believe that all persons, with the exception of those suffering from psychoses, should be charged for use of mental health services.

in addition to evaluating the responses of the total professional group, it would be possible to identify subgroups of professionals whose responses differed significantly from each other. In this way, the effects of sex, age, profession, direct treatment involvement, and fee charging on attitudes toward fee charging could be determined.

Results

Replies were received from 203 (68.3 percent) of the 297 questionnaires mailed out. Six of these were from persons who stated that they could not meaningfully complete the questionnaire because they were subprofessionals not involved in mental health work. The 197 usable, but often not completely filled out, questionnaires were received from 27 psychiatrists, 33 psychiatric residents, 27 psychologists, 94 social workers, and 16 others (e.g. psychiatric nurses, school counselors, hospital attendants). The rates of return for the various professional groups were similar (61.3 percent for psychiatrists and psychologists, 68.1 percent for social workers, and 68.3 percent for residents).

Review of all the responses, considered as a group, suggests that the respondents feel: that the best fee schedule is one that requires all clients to pay a fee based on their ability to pay; that most therapists use fee payment as a part of treatment; that size of fee is unrelated to therapists' qualifications; and that the poor are less likely to use an agency charging fees than an agency that does not. They also reported that the best method of financing mental health services relies on a combination of fees, dona-

tions and taxes, that it is best for the fee to be established by negotiation between the therapist and the client, and that fees are of greater importance with clients who are suffering from character or neurotic difficulties than with those suffering from psychoses.

When the respondents were divided into groups based on sex, age, and whether or not fees are charged to all clients, few significant differences were found. On the other hand, when the responses were divided into groups based on professional affiliation and involvement in providing direct services, many significant differences were found. Because the patterns of these differences were similar, the two categories were tested for independence. It was found that professional affiliation is not independent of involvement in direct treatment ($\chi^2=21.07$, $p<0.001$). In view of this, the involvement in direct treatment category was deleted, with differences between groups presented only for professions.

Initial evaluation of the data by professional groups indicated that there was no substantial difference between the responses of the psychiatrists and the psychiatric residents. In the presentation of the findings that follows, therefore, the category "psychiatrist" will include both psychiatrists and psychiatric residents. Significant differences between groups of mental health professionals were found on 10 of the 22 items in the second section of the questionnaire. Psychiatrists feel that agencies charging fees provide a different quality of services than do agencies not charging fees, but do not feel strongly that the "poor" are more or less likely to use agencies charging fees. Psychologists and social workers, on the other hand, are equivocal about the effect of fee charging on the quality of services, but feel that the "poor" are less likely to use agency services when agencies have fee schedules. All three professional groups

disagree that the size of a fee reflects the therapist's qualifications, with psychiatrists and social workers feeling more strongly on this question than psychologists.

It is clear that none of the three professional groups is in agreement with treating any client, be he welfare or middle class, on a no-fee basis. Social workers and psychologists, however, report significantly less opposition to this policy than do psychiatrists. This finding is suggested by the responses of the three groups to the item dealing with a token fee for "poor" clients. All three professional groups tend to agree with this statement, but psychiatrists are in stronger agreement with it than are psychologists, who agree with it more strongly than do social workers. All three professional groups indicate most support for a fee schedule based on ability to pay. Examination of certain items suggests, though, that the professions have different conceptions of what "fits into budget" means. Psychiatrists are equally positive to fee policies which "fit into budgets" and "force minor budget modifications" while psychologists and social workers look much more favorably upon a fee that "fits into a budget" than on a fee that "forces minor budget modifications".

The three professional groups were in agreement with each other on the desirability of different ways of financing a mental health service. Rank order correlations between the groups ranged from 0.82 to 0.96, all significant at the .05 level. The groups agreed that, in order to provide maximal benefits to clients, a financing method based on taxes, donations and fees was the most desirable. Other methods, in order of decreasing acceptability, were combinations of taxes and fees, donations and fees, taxes and donations, and then taxes alone, fees alone, and lastly, donations alone.

There was general agreement among the professionals that fees are neither impor-

tant nor unimportant in work with clients who are hallucinating and/or delusional. Psychiatrists feel, however, that fees are important in work with clients who present complaints such as extreme dependency, homosexuality, depression, voyeurism, and kleptomania. Psychologists and social workers feel that fees are of lesser importance in the treatment of persons with these other complaints.

Other findings show that when presented with a choice between a sliding fee scale with ranges from one to fourteen dollars or from zero to fifteen dollars, psychiatrists—more often than psychologists or social workers—elected the fee scale with a range of one to fourteen dollars. The last comparison, one between professional groups and whether it is best for the therapist or a non-therapist to set each fee, reveals that psychiatrists and social workers favor the therapist setting fees while psychologists favor having a non-therapist set fees.

Discussion

The results presented above make it clear that mental health professionals believe that all persons, with the exception of those suffering from psychoses, should be charged for use of mental health services. The fee is charged in order to maximize the client's benefit from the use of mental health services. While all three mental health professions agreed with this position, psychologists and social workers endorsed this position significantly less strongly than did psychiatrists.

The three professional groups agreed, again with different degrees of intensity, that the best fee is one that fits into the client's budget. In addition, psychiatrists tended to support a fee which requires a mild sacrifice on the part of the client. Psychologists and social workers felt more strongly than did psychiatrists that the ex-

istence of a fee schedule would interfere with the "poor" clients' use of a mental health agency. These findings place the attitude of the mental health professional in opposition to the Community Mental

Others suggest that it is not the fee itself, but the professional's own attitude toward it, that determines whether or not fee charging is a necessary and/or useful adjunct to treatment.

Health Centers Act's provisions assuring mental health services to all persons irrespective of their ability or inability to pay for them.

A substantial part of the difference between attitude and Act may, however, be more apparent than real. As an example, the questionnaire employed in this study measured attitudes regarding charging for services rather than attitudes regarding being paid for services. If one disassociates these two phenomena, it is possible that professionals, while believing that fee charging is important, believe that payment or non payment of the fee is unimportant. Should this be the case, and the fee collecting practices of many agencies suggest that it is, there is no conflict between the professional's insistence on charging fees and the Act's prohibition of denying services due to inability to pay for them.

Another potential source of apparent rather than real difference between professionals and P.L. 88-164 is in the area of quality of service to be rendered. Responses to the questionnaire indicated that fees are important if maximum benefit is to be obtained by the client using mental health services. Although it was not assessed, it may be that professionals would have no objection to no-fee services if less than maximum benefit was acceptable.

Probably the most serious problem in im-

plementing the Mental Health Centers Act uncovered by this study is that of providing services to those persons who will not use available services that are tied to a fee schedule. Mental health professionals disagreed with the statement that the "poor" are equally likely to use agencies that do or do not charge fees. While it is possible that their disagreement indicates a belief that the "poor" are more likely to use a fee charging than a non fee charging agency, it is highly unlikely that this is the case. If the "poor" will not use an agency which charges fees, then that agency's services are not available to them.

More substantial research is required to determine the real effect of fee schedules on the use of mental health services by the "poor". If the observation of the professional is verified, the present method of delivering mental health services to the "poor" must be altered. Among the alternatives that could be used are informing the "poor" of our disassociation between charging fees and being paid those fees, accepting treatment conditions that will result in less than maximum benefit being achieved from services, or re-examining our belief that fee charging is important for client benefit from mental health services.

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William H. Clayton, M.S.W., Ph.D.

Release of the Chronic Psychiatric Patient

The author describes a group of long-term hospitalized psychotic patients in terms of length of hospitalization, community placement and, release and readmission patterns fifteen years after their release. All patients still living had been out of the hospital for at least 90 days. Almost one-third had no readmissions for psychiatric treatment for up to fifteen years. Between 8 and 10% of the group are hospitalized at any given time, but almost all are later returned to community living.

In 1958, Ellsworth, Mead, and Clayton² published a paper reporting what was then an unusually high percentage of chronically hospitalized patients released from the Veterans Administration Hospital, Salt Lake City, Utah. That report concerned 72 veterans diagnosed as schizophrenic who were transferred in groups to the then new Salt Lake Veterans Administration Hospital in 1952-53 from other Veterans Administration Hospitals in nearby states. At the time of their transfer, the mean length of continuous hospitalization for these patients was 5.8 years. The average age was thirty-six years. Fifty-four had never married, fifteen were divorced, one was a widower, and only one was married. Chances for release of patients in this group were statistically very low. The study by Kramer³ and his associates which indicated that release from psychiatric hospitalization declines markedly after two years has pertinent reference here to stress the minimal discharge potential of this group.

At the time of the original report on this group, almost one-half (48.6 percent) had

been released after an average of more than five years of continuous hospitalization. The report presented here further describes and discusses 71 of the original group and follows their progress up to fifteen years after their initial transfer to the Salt Lake Hospital.* As of December 1964, seventy of the seventy-one patients (98.6 percent) had achieved a release from the hospital for 90 or more consecutive days of residence in other than a hospital setting; and, of those living whose whereabouts are known, 90 percent are now (1969) in nonhospital settings.

Release and Readmission

The first of these veterans was released in May 1953 after more than two years of continuous hospitalization. From that date to December 1964, all but one of the group were released to spend at least 90 consecutive days outside a hospital setting. The one patient not released died in the hospital. On the fifteenth anniversary date of their transfer to Salt Lake, fifty-two were known to have been living in the community, most having been discharged from

Dr. Clayton is a social worker at the Veterans Administration Hospital, Salt Lake City, Utah 84113. Data were gathered while the author was with the Veterans Administration's Program Evaluation Staff, Lee Gurel, Ph.D., Director.

* One of the original group of 72 was dropped from the current study because of a later diagnosed medical condition and release from a medical ward.

a period of trial visit. The status of the others included eight who had died; two who were in Veterans Administration Domiliaries; three whose whereabouts were unknown in spite of a check of Veterans Administration records and family contacts; and only six, or 8 percent of the total group, who were in a psychiatric hospital at that time.

While there have been readmissions among this group, the return rate in the first year after release was no greater than reported for some other groups of psychiatric patients. Return to the hospital for treatment on a psychiatric ward within the first year was 29 percent. Readmission figures continued to rise for the Salt Lake group after the first year but at a much slower rate. For these patients, the readmission figure rose to 67 percent after all patients had been out alive in the community for at least two and up to fifteen years. Of those readmitted, 94 percent were again returned to community living. In considering all seventy patients released, a substantial number—23 patients, or 32 percent—have not had a readmission for psychiatric treatment for up to fifteen years. Two of the patients have been hospitalized for short periods for medical problems. Three other patients were returned from trial visit for a few days for physical examinations. These admissions were routine; and, unless the patient remained on a psychiatric ward for more than seven days, this was not considered a readmission for psychiatric treatment in this study.

The figures described are similar to release and readmission rates of newly admitted schizophrenic patients as reported by Sherman, *et al.*,⁹ who described a group of 588 patients, 90 percent of whom had left the hospital at the time of their report. One-third were never readmitted after discharge. In a follow-up of the first 100 patients released in each of three consecutive

years, Kris⁶ found that the average return rate was the same for both acute and chronic patients—37 percent after five years. A number of other studies of chronically hospitalized psychiatric patients also describe high release rates. For the most part, however, these groups consisted of patients to whom special attention was given for specified periods of time. Deykin¹ reported the release of thirteen of sixty psychiatric patients hospitalized five or more years after transfer to an acute treatment center. In a special project involving psychotic patients selected for placement at home, Shea⁸ described the successful release from the hospital of one-half of a group of long-time hospitalized (average of 14 years) patients.

The Salt Lake Hospital has had the staff, the hospital treatment facilities, and the community resources, a combination which appears to have had the effect of a special emphasis but which actually occurs in a regular ongoing treatment program. The philosophy on the wards at Salt Lake has been described by Ellsworth² during the earlier part of the period under study. During this time, the staff efforts focused upon the individual strengths and assets of the patient rather than upon his psychopathology; the patient was encouraged to participate in making plans to leave the hospital and these were discussed carefully with him and a definite goal outlined; as much responsibility as the patient could manage was given to him in the various activity and therapy programs throughout the hospital. Patients showing considerable psychopathology were sometimes released if they had demonstrated an ability to get along adequately in a social situation as demonstrated during weekend passes at home or elsewhere in the community. Encouragement was given to participate in patient-government meetings, in weekly patient-staff meetings, and in an individual

work assignment of the patient's own choosing.

Placement in the Community

In planning for release of these chronic patients, first consideration was given for placement with relatives in the Salt Lake area. Other kinds of community placements, nursing homes and foster homes, were then used as necessary and appropriate. Of the seventy patients released, thirty-five (50 percent) were placed into non-family, supervised living situations, i.e., nursing homes, foster homes, or Veterans Administration Domiciliary; twenty-eight (40 percent) left the hospital to live with relatives, in most instances with parents; and seven (10 percent) of the patients were released to their own responsibility. For purpose of comparison, on the fifteenth anniversary date of their transfer, of those known to be in the community ($N=54$), thirty (55 percent) were living in supervised, non-family settings; eighteen (33 percent) with relatives; and six (11 percent) living alone.

Related Factors

There are, in addition, certain other factors reported in the literature that appear to be related to both release from psychiatric hospitalization and to stay in the community. In a report of hospital effectiveness, Gurel⁸ described certain Veterans Administration Hospitals as "nontraditional," that is, hospitals reflecting such variables as higher staff to patient ratio—particularly professional staff; a high rate of foster home placement; high level of research funding; and what appeared to be a more liberal, less custodial kind of atmosphere. He reported that this factor of "nontraditionalism" correlated highly (.72) with the release of chronic patients. The Salt Lake Veterans Administration Hospital typifies this active type of treatment setting and

was, in fact, one of the hospitals in his study. In her study of the chronic schizophrenic, Deykin¹ reported several variables that contribute to successful discharge and community adjustment of the chronic patient. These include the use of medication, family and community tolerance of the patient's behavior, and resources and support for the patient plus careful discharge planning by the social worker. These factors were characteristic of the Salt Lake Hospital as all patients were receiving medication and all families were involved in planning for the patient's release whether the patient was released to the family or other setting; and some judgments were made and conclusions reached as to their reactions to the patient's behavior. Sustained family interest as another related variable was found to be important in enabling the long-term hospitalized patient to return to and remain in the community as reported in a study by Wessler and Kahn¹⁰. At Salt Lake efforts did not diminish over the years to involve family members in maintaining contacts between the patient and the community. These were accomplished through the use of hospital visits to the patient from the family, weekend passes, and other activities away from the hospital. If the family did not sustain the contact, it was not uncommon for the social worker to telephone the family to suggest that the patient be taken for the weekend or to discuss with the family the patient's overall adjustment. Tolerance of deviant behavior by the family was another factor also suggested by Wessler and Kahn¹⁰ related to the chronic patient remaining in the community. In our experience families which were not tolerant of deviant behavior did not prove to be adequate nor appropriate resources for community placement.

On the other hand, nursing homes, in which a large number of these patients were placed, appear to be settings which

are quite tolerant of certain psychotic behavior, and particularly so when they have the support of the hospital through the trial visit follow-up contacts.

In each instance at Salt Lake, the patient left the hospital with medication which was continued while the patient was in the community; close follow-up by Social Work Service was maintained coupled with the continued availability of consultation by the ward physician. These variables, combined with a level of tolerance of the patient's behavior either by the family or in the nursing home situation, all appeared to contribute to the low rate of readmissions of this group.

Summary

A high rate of release of chronic psychiatric patients appears to involve a focus of effort by staff toward that goal. Chronic psychiatric patients can be released after many years of hospitalization provided there are sufficient numbers of staff with time to carry out the many facets of treatment and planning necessary along with a definite structure and philosophy within which to carry out such a program. The release of psychiatric patients from any period of hospitalization is dependent upon a number of factors, however. In addition to availability of staff to carry out the treatment and continued effort toward discharge, there needs to be some observable change noted in the patient in the intensity of symptoms from the time of admission to release; a quality of social behavior which is acceptable to the family or community resource used in discharge; and some means of financial support for community living. Insofar as patients remaining in the community, it would seem that in the presence, if not influence of other variables described above, i.e., medication and follow-up support, many of these patients are able to

maintain a level of adjustment in the community which obviates additional hospitalization.

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Gerald Globetti, Ph.D.

Grace Pomeroy, M.A.

Characteristics of community residents who are favorable toward alcohol education

Two communities were surveyed to determine their attitudes toward alcohol education. It was found that factors of race, sex, age and social class were important. White parents in both communities were equally favorable while Negro parents in one town were less favorable. More men than women were favorable in one community, with the converse being true in the other. In both towns, those below 35 years or over 50 were less favorable than those in the 35-49 age range. Participation in formal community organizations influenced attitudes differently in each town. Regardless of class the white community seemed more favorable.

Introduction

Alcohol has been praised as a medicine, as a social lubricant which facilitates communication and strengthens group bonds, and as a behavior modifier that relieves the individual from the tensions of daily living. Despite these ascribed values, however, drinking has often been negatively regarded and attempts have been made to regulate or to abolish it.

The authors are Associate Professor and Assistant Sociologist, respectively, in the Department of Sociology and Anthropology, Mississippi State University, State College, Mississippi 39762.

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Because of the lack of effective mechanisms to enforce the laws, the high cost of enforcement, and—perhaps of primary importance—the absence of popular support, prohibition failed in this country. With the demise of the legal control approach, other forms of management emerged primarily concerned with diminishing excessive drinking. One of these forms, which has gained increased momentum in recent years, is the modern alcohol education movement.

The education approach is based on the scientific gathering of facts about intoxicants and their use, combined with the unbiased transmission of the current level of scientific knowledge to the general public. The assumption behind this model is that a causal relationship holds between con-

A much larger proportion of males than females was favorable toward alcohol education in Hilltown. . .

trolled presentation of information and modification of attitudes.

The Sociology Department at Mississippi State University, under the auspices of the National Institute of Mental Health and with the cooperation of the State Department of Education, has initiated in two Mississippi localities a demonstration community oriented alcohol education program. The aim is to show that it is possible to saturate a community with information about alcohol and alcoholism, thereby creating an awareness of local needs in these areas as well as assisting the community in developing means to meet these needs.

Survey

The preliminary planning included an analysis of the current opinions in regard to alcohol education held by residents of the two communities. Accordingly, this paper reports on a survey designed to delineate some of the social and cultural factors associated with a favorable attitude toward programs of instruction about alcohol. This study was undertaken with the realization that the existing imagery regarding education about alcohol could facilitate or retard the successful implementation of the program. Furthermore, as a prerequisite for effective teaching, understanding of the expressed needs and opinions of those persons to be involved in the program was essential. In this context alcohol education can be more effectively tailored to the total community. Finally, this survey is prompted by the fact that the two communities involved in the program exhibit different definitions of beverage alcohol, which may be reflected in distin-

guishable attitudes toward alcohol education.

In one locality, hereafter called Delta-ville, the use of intoxicants has been a traditional and integral part of the life styles of the middle and upper classes. Consequently, there is a favorable image of alcohol if it is handled normatively. On the other hand, the community designated as Hilltown defines alcohol in an unequivocal moral tone. Drinking of any kind is viewed, at least officially, as disreputable and numerous pressures are exerted to control alcohol use. Many of the inhabitants, furthermore, express a causal nexus between drinking and social ills. Alcohol use evokes much apprehension and public concern in this second community.

Research

This analysis was based upon a universe of parents of high school students in the communities studied. The sampling plan consisted of stratifying this universe by the factors of community of residence and race, and taking simple random samples within each stratum. This procedure yielded a sample size of 515 parents of which 464 were contacted and interviewed.

The items and scoring procedures are as follows: *

1. Do you think the general public has an understanding of alcohol and alcoholism? Responses of "no" were scored 1 and answers of "yes" or "don't know" were scored 0.

2. Do you think the schools are doing

* For a comprehensive discussion of these procedures see Gerald Globetti and Elaine Cockrell, *Selected Socio-Cultural Factors Associated with Favorable Attitudes Toward Alcohol Education*, State College (Social Science Research Center Preliminary Report No. 5) March 1965. Also, a complete set of tables including all statistics are available from the authors.

all they should to teach the facts about alcohol and alcoholism? Responses of "no" were scored 1 and answers of "yes" or "don't know" were scored 0.

3. Do you think the public has any responsibility toward the alcoholic? An answer of "yes" was assigned a score of 1, whereas a response of "no" or "don't know" was scored 0.

4. Do you think there are any other agencies or groups in this community besides the school which should be doing more to teach the facts about alcohol and alcoholism? An answer of "yes" was assigned a score of 1, whereas a response of "no" or "don't know" was scored 0.

5. What is your feeling toward the alcoholic? Replies of sympathy and understanding were scored 1, whereas answers of disgust, ambivalence or indifference were scored 0.

Scores on this index could theoretically range from a low of 0 to a high of 5. For analytical purposes, these coded responses were divided into three categories. Parents who scored from 0 to 2 on the index were considered as being mildly favorable toward alcohol education; those who scored 3 were viewed as being moderately favorable; and those who scored from 4 to 5 were seen as being highly favorable toward alcohol education. The dependent variable of favorability toward alcohol education was then studied in the light of three im-

variables, organizational structures and stratification patterns.

Findings

Demographic variables

There were, as expected, some differences between the two communities in respect to demographic variables. In general, there was a more favorable predisposition toward alcohol education in the Delta community than in Hilltown, but this variation was attributable to the Negro population. With race controlled, white parents in the two communities were equally favorable toward alcohol education; whereas, the Negro parents in Deltaville tended to be more favorable than their counterparts in Hilltown. Negro parents in both communities were much less inclined to favor alcohol education than white parents.

By sexual status, it was found that a much larger proportion of males than females was favorable toward alcohol education in Hilltown, while the converse was true in Deltaville. Among the white population females were more prone to accept alcohol education than males, but in the Negro community it was just the opposite.

A curvilinear relationship existed between the factors of age and favorability toward alcohol education in both Deltaville and Hilltown. That is to say, parents between the ages of 35-49 years indicated a high acceptance of alcohol education; whereas, those below 35 years or over 50 years were either mildly or moderately favorable in this respect. This finding held true for both Negro and white parents.

Since each community contains a number of formal associational groupings, these existing structures could be utilized for support of the educational program and as channels for accelerating communication. An analysis was made, therefore, to ascer-

Formal participation in civic and professional organizations was related to a high degree of favorability toward education about alcohol in Hilltown but not in Deltaville.

portant community dimensions which have relevance to the establishment of alcohol education programs—namely, demographic

tain if a person who was an active participant in religious and community organizations would favor alcohol education.

Here again several differences between the two communities emerged. Formal participation in civic and professional organizations was related to a high degree of favorability toward education about alcohol in Hilltown but not in Deltaville. Moreover, active participation in religious activities was positively correlated with a favorable predisposition toward alcohol education in the hill community but not in the Delta community.

These data indicate that in Hilltown the formal organizational channels were receptive to alcohol education and would be inclined to welcome an expanded program of alcohol education among their activities. The same, however, cannot be said for the formal organizations in Deltaville.

An analysis was made of the stratification patterns in the two communities in order to see which social class would be more receptive to alcohol education.

Two measures of social class were employed, namely, the formal educational level and family income of the respondents. The data revealed that in both communities these factors were positively related to a favorable attitude toward alcohol education. However, with race controlled, this relationship, in both instances, vanished among the white parents although it was maintained in the Negro population. Therefore, it appears that regardless of class, the white community is predisposed toward favoring some kind of instruction concerning alcohol.

Summary and Conclusions

This research demonstrates that instruction about alcohol must begin with a focus on community. Not all communities necessarily have the same or equally intense

There are no generalized attitudes toward alcohol and alcohol education that are applicable to all social classes in a community.

problems associated with the use of intoxicants, so there can be no one program of alcohol education nor an "alcohol education package" applicable to all communities. Several basic differences in attitudes toward alcohol education were found in Hilltown and Deltaville. For example, the value systems which surround beverage alcohol and its use are dissimilar in the two communities, and parents in the Delta community appear to be more disposed toward acceptance of instruction about alcohol than do parents in Hilltown. Comparing the communities, we found that organized agencies, whose cooperation is essential for implementation of alcohol education programs, exhibit fundamental divergences. Professional, civic, and religious groups in Hilltown could be used as channels for adult education; whereas, in Deltaville, the school is the most likely agency for initial involvement. In essence, therefore, it appears that alcohol education programs in Mississippi, and possibly elsewhere, must be community oriented to be effective.

Thus, if alcohol education is to be locally oriented, it follows that an educator must know the community. Effective instruction about alcohol necessarily involves the whole of organized community life. The simplest beginning in initiating an education program concerning alcohol is to ascertain how receptive certain subgroups within the community are toward such programs. Lacking this information, an educator runs the risk of engendering hostility.

Understanding of a community necessitates definition and delineation of the di-

mensions of it which have relevance to alcohol education. Some relevant community features are stratification patterns, demographic characteristics, organizational structures, value systems, ecological patterns, leadership and power structures, and systems of informal interpersonal relationships. This analysis has partially measured attitudes toward alcohol education within the first three of these dimensions and has recorded some marked and significant differences between the two communities in several of them. For instance, the educator can expect less resistance to alcohol education from males in Hilltown and from females in Deltaville. In both communities he can expect limited receptivity among Negro parents and elder citizens at the inception of the program. Obviously, additional education is essential prior to approaching these uncommitted segments of the adult community.

Furthermore, the organized structures of the community (such as the church, civic and professional groups in Deltaville) do not exhibit the type of readiness that would be desirable to an educator seeking forceful target groups to involve in the initiation of an alcohol education program. Rather, these organizations undoubtedly need to be encouraged through an expanded program of adult education before their facili-

ties and energies could be mobilized. The converse seems to be true of Hilltown.

Finally, the action worker must realistically take into account that there are no generalized attitudes toward alcohol and alcohol education that are applicable to all social classes in a community. These data apparently reaffirm the importance of education and socio-economic status in the acceptance of new ideas and practices. Changes in approaches to traditional problems are likely to find their strongest opposition among the less educated and lower class levels. These groups are inhibited from accepting programs by insufficient knowledge, inadequate channels of communication, lack of confidence in experts and fear of the new and untried.

These, therefore, are some of the groups and groupings within two Mississippi communities which may be utilized to teach effectively about alcohol. Perhaps the major significance of this research, beyond its immediate implications for alcohol education workers in Mississippi, is its demonstration that communities within the same geographical area vary in terms of their attitudes toward alcohol education. Nonetheless, despite its limitations, this study can provide a framework as to how an educator might go about assessing a community before an alcohol education program is implemented.

Robert W. Brissenden, M.A.

Henry L. Lennard, Ph.D.

Organization of Mental Health Services and its Effect on the Treatment Career of the Patient

The authors present data from a recent study to show that the location of a mental health service within the organizational framework of a community mental health center assures wider representation of minority groups, decreases delay in seeking treatment and changes patterns of treatment.

Introduction

There are three possible frameworks within which state supported mental health services may be organized: they can be operated under the auspices of a department of public or mental health; directly under city auspices; or as a part of a county medical facility.

The organizational framework and the physical location of these services are significant factors in determining: a. what kinds of patients will be served; b. whether there is delay between the appearance of symptoms and the seeking of treatment; and c. the period of time patients will be kept or remain in treatment.

Findings from a study of San Joaquin County's Mental Health Services,¹ recently

completed by the authors, demonstrate how locating mental health services administratively and physically within the complex of the County Medical Center significantly affects the above questions.

The results of this study, in our view, have general relevance for the organization and location of community mental health centers and services.

Method

We conducted 90 interviews with patients at San Joaquin County Mental Health Services.* These interviews were designed to determine more precisely than was possible from an examination of records the major social characteristics of patients. On the basis of the information collected in this fashion we developed a composite portrait of the "consumer" of mental health services. In addition to delineating the social profile of patients, we explored the treatment history of each one, both at the San Joaquin County Mental

* Interviews were conducted on two days, which were determined to yield a representative sample of the patient population.

Mr. Brissenden is Assistant Administrator of San Joaquin General Hospital. Dr. Lennard is Associate Professor of Medical Sociology at the Department of Psychiatry, University of California, San Francisco Medical Center, San Francisco, California 94122. The authors wish to express their appreciation to Dr. Louis M. Barber, Administrator of the San Joaquin Medical Facilities for his interest and support of the study on which this article is based.

Health Services and at other agencies and facilities in the county.

Discussion of Findings

Utilization of Mental Health Services

The various forms of psychiatric and especially of psychotherapeutic treatment have until recently been utilized mainly by educated middle and upper income individuals. Persons of lower socio-economic status, and especially members of minority ethnic groups, have tended to be less visible in private and outpatient facilities, and when in need of treatment, are most likely to be found as patients in mental hospitals.^{3, 4} Although the situation is changing as a result of concerted federal and state programs to include a broader population base in the spectrum of services, results are still far from satisfactory in many communities throughout the country.

Almost 19 percent of the population of San Joaquin County was classified as non-white in the 1960 Census. Of those, five percent are Black and the others Filipino, Japanese and Chinese. Twelve percent of the county's population is classified as white of Spanish surname.

It was, therefore, of interest to determine to what extent members of these minority ethnic groups are included in the patient population of the San Joaquin County Mental Health Facility and to observe whether the particular organizational framework (that of a general hospital) appears to have an effect on patterns of utilization of the services by members of minority groups.

San Joaquin County Mental Health Facilities serve a substantial number of Black and Spanish-American clients. Indeed, compared with their ratio in the population of San Joaquin County, there are more

Spanish-Americans (19 percent) and about as many Blacks (8 percent) represented in the outpatient population of San Joaquin County Mental Health Services. Such a high representation of minority and low socio-economic groups is not generally found in mental health outpatient services.

Underrepresentation of minority and low socio-economic groups in outpatient mental health services is ordinarily explained by the fact that members of such groups are likely to be uninformed about the availability of mental health services, and in addition are much less likely to identify their problems as being of psychological origin and to actively solicit help for them.

Mental health services or community mental health centers need to be located within or as part of a general hospital.

But this does not seem to be as true of San Joaquin County as it is of other localities. The San Joaquin situation, however, may be different because of the organizational framework of its Mental Health Services and the implications of this arrangement for patterns of referral and sources of patients for the Mental Health Services. From one-third to one-half of all patients seen at San Joaquin County Mental Health Services are referred there from one of the medical services of the hospital. It is the general hospital, therefore, which identifies and generates patients for the San Joaquin County Mental Health Services.

These findings lend powerful support to the argument that mental health services or community mental health centers need to be located within or as part of general hospitals. In this way, some of the obstacles

to the utilization of such services are overcome.*

Delay in Seeking Treatment

For many individuals there often is little correlation between the appearance of a distressing symptom, its identification as a sign of illness, and any subsequent effort to seek medical care.

Even when symptoms are correctly identified as signs of psychological illness, economic circumstances and social attitudes may prevent the individual or his family behavior pattern (21 percent). For the from seeking professional advice and help.**

About one fourth of the patients interviewed by us sought help immediately (23 percent). Almost the same number of patients delayed in seeking professional services for more than one year after the onset of the distressing symptom or disturbing behavior pattern (21 percent). For the majority of those interviewed (47 percent), the time lag between the identification of a problem and the procurement of professional help was, however, less than one year. This delay on the part of those who finally do obtain help at San Joaquin Mental

Health Services is considerably less than the experience of other public and private mental health outpatient services.^{3, 4}

Many of these patients, as we have already pointed out, are channelled to mental health services from the general hospital which they first approach for service. The patients' familiarity with the general hospital, the public visibility of the general hospital, together with its physical proximity to the mental health services appear to constitute the salient features which facilitate utilization of psychological and psychiatric treatment resources.

Patterns of Referral

Prospective patients frequently move between professionals or are referred from agency to agency until they finally reach an appropriate treatment resource.⁵ Special attention was therefore paid to the referral and treatment career of patients at the San Joaquin Mental Health Services.

Interestingly, the referral career of the patients interviewed in our study seems to be less complex than anticipated. The majority (61 percent) first seek treatment either at San Joaquin General Hospital or di-

These data suggest that patients in general are either not encouraged or not willing to utilize mental health services for extended periods of time.

* While the trend in San Joaquin County is encouraging, one should not conclude that the mental health service needs of minority group members are being fully served in this community. In comparison with the ethnic distribution of the general hospital population, the representation of minority ethnic groups in the mental health service population is still low.

** Landy and Albert, in a study of patients at the Massachusetts Mental Health Center, report a median delay of 22 years between onset of symptoms and application for treatment.

rectly at the Mental Health Services. Almost a third (29 percent) of patients treated at San Joaquin Mental Health Services originally approach the General Hospital for medical help and are subsequently referred to Mental Health Services. The General Hospital constitutes by far the most important source of patient referral for the Mental Health Services. Physicians and psychiatrists together refer only half as many patients (16 percent) to the Mental Health Services.

In another paper² we refer to the potential "family doctor role" of the General Hospital. San Joaquin General Hospital does indeed function in this manner in relation to Mental Health Service referrals. Most of the patients at Mental Health Services have already utilized the services of

Most of the patients at Mental Health Services have already utilized the services of the General Hospital for other medical problems.

the General Hospital for other medical problems. The General Hospital, therefore, becomes the familiar and logical resource to be approached with problems which the patient perhaps is unable to identify as being specifically within the province of the psychological or psychiatric professions.

Community agencies, especially those concerned with law enforcement, also employ the General Hospital as the primary resource for diagnosis and referral. Individuals acutely upset are taken to the General Hospital Emergency. The proportion of Mental Health Service inpatients routed by way of the General Hospital is even higher (40 percent) than for Mental Health Service outpatients.

Patient Turnover and Discontinuity

Patients will be kept or remain in treatment for briefer or extended periods of time, depending on the theoretical models of those giving psychiatric and psychological forms of treatment. A staff committed to "deep" or "reconstructive" forms of treatment will view therapy as a long term process. Mental health personnel who see their job as helping persons over periods of stress or during an immediate crisis will be satisfied with intervention of more limited time or scope.

Patients, too, have different conceptions of services to be obtained from a mental health facility. Those who see the function of such a service as helping them over a period of immediate stress or discomfort will not see much justification for returning to see their therapist for a broader exploration of their interpersonal and intrapsychic processes. At the same time they will be ready, on the basis of this model, to resume treatment if a new crisis occurs and when they again experience distress or disability from their symptoms.

From the point of view of evaluating the operations of a mental health service, it makes a difference whether patient turnover is due to termination of treatment or to their simple "dropping out" of treatment; whether many individuals are being serviced or the same individuals are being seen over and over. For the community at large and its need for mental health services, a study of treatment histories of patients at San Joaquin County's Mental Health Services is important.

The less staff time that is absorbed by a single patient, the larger the number of patients can be served. On the other hand, there is little to be gained if insufficient time is devoted to individual patients and if patients are not kept in treatment long enough for some sort of temporary cure to take place or until immunity against a further breakdown is achieved.

Of the patients interviewed in the study, 69 percent were classified as "continuous" patients, that is, they had been receiving help at San Joaquin Mental Health Services without interruption ever since they had been accepted as patients. Thirty-one percent of those interviewed were classified as "discontinuous" patients, that is, they had had one or more periods of continuous treatment and had either been terminated

by the therapist or had left treatment themselves on one or more occasions.

Of the "continuous" patients 76 percent had been patients at San Joaquin Mental Health Services for less than six months. Only 12 percent had been in treatment, on a regular basis, for more than one year. These data suggest that patients in general are either not encouraged or not willing to utilize mental health services for extended periods of time.

However, for most "discontinuous" patients (79 percent) the initial treatment had begun more than one year ago and for almost one third (29 percent) the first contact with the mental health service occurred more than six years previously.

Patients at San Joaquin Mental Health Services rarely stay in treatment for longer than six months (either by decision of the therapist or through their own choice). There is also a smaller group of patients who are treated primarily with drugs and who are not seen intensively, but who may have brief contact with a therapist once a month or less often.

On the basis of these observations it is apparent that the treatment model underlying the operation of San Joaquin Mental Health Services more closely parallels that followed by the general hospital in its treatment of medical patients than it does treatment paradigms current in private psychiatric or psychotherapeutic practice.

Our data show that a majority (64 percent) of the patients using San Joaquin Mental Health Services have been and will, in the future, remain patients at the San Joaquin General Hospital. This fact provides some assurance to the staff that multiple avenues to treatment remain available to the patient should he become worse and again experience psychological distress and a recurrence of symptoms.

Conclusion

Though we assume that the mental health needs of some minority group citizens in the county are still unmet, our data seem to indicate that the unique relationship of San Joaquin Mental Health Services to the General Hospital has helped to overcome some of the obstacles usually associated with utilization of mental health services by minority groups.

The following factors tend to facilitate use of the County Mental Health Services and decrease obstacles to utilization of treatment services. Because the Mental Health Services are located within the relatively familiar framework of a medical center, the sense of strangeness usually associated with psychiatric illness and treatment is somewhat mitigated. Since patients within the hospital are often referred from service to service, a referral to Mental Health Services becomes a part of the routine of medical care. The physical proximity of Mental Health Services to the General Hospital further makes it less likely that patients will be "lost in transit" or fail to follow through on referrals.

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Catherine Bentinck, M.A.

Alex D. Pokorny, M.D.

Byron A. Miller, M.S.W.

Social Adequacy of State Mental Hospital Patients

A stratified sample of a cross-section of state mental hospital patients was studied for social adequacy. Almost one-fourth of the total group of subjects was found to be socially adequate, suggesting that many mental hospital patients do not need hospitalization.

Introduction

It is widely believed that the mental hospital environment has a negative impact on the patient, especially the long-term patient. Gruenberg has referred to this phenomenon as the "social breakdown syndrome" and has presented a tentative seven-stage formulation of its pathogenesis.¹ We choose to look at mental hospital patients from the opposite point of view, from the standpoint of their "social adequacy". In this paper, we attempt to evaluate this characteristic and to identify some of its correlates in a sample of state mental hospital patients.

The data presented here were obtained in a 1966 survey of Texas State mental hospitals. This large-scale survey² was carried out primarily for program planning pur-

poses, and consisted of a multi-disciplinary cross-sectional study of the resident population of Texas state mental hospitals. A 10% stratified sample (1,537 patients) was studied in detail by teams of psychiatrists, internists, neurologists, psychologists, and social workers brought in from outside the hospital system. The nursing care status of all patients was appraised by state hospital nursing personnel. Information from the community was also obtained by questionnaires sent to relatives or acquaintances of patients.³ All findings were studied and rated by a review panel composed of two psychiatrists and two social workers. This panel made final decisions on diagnosis and appropriate placement categories.

Method

Seventy-five social workers, under supervision of the authors, reviewed and abstracted the hospital records of the 1,537 sample patients and personally interviewed 1,477 (97%) of these patients. The record reviews and patient interviews were structured so as to yield extensive information about current and past family history. The social workers were also asked to evaluate the current "social adequacy" of the patients, i.e., how well they were capable of

The authors are affiliated with the Psychiatry Service of the Veterans Administration Hospital, Houston, Texas, and the Department of Psychiatry, Baylor College of Medicine, Texas Medical Center, Houston, Texas 77025. During 1966-67 they served as consultants to the Texas Department of Mental Health and Mental Retardation.

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functioning in social situations, by completion of the Pinchak-Rollins Social Adequacy Rating Scale (SARS).² This scale measures a subject's functioning in eight major areas of social adjustment; (a) use of money, (b) personal appearance, (c) personal habits, (d) work assignments, (e) social group attendance, (f) social group participation, (g) other patients and personnel, (h) interpersonal relationships. Each major area is rated in one of five steps, from adequate to inadequate. There is also an "unknown" category to be used when available information is not sufficient for rating purposes. The scores for each of the eight adjustment areas are added to give a Social Adequacy Index, which may range from 8 (highly adequate) to 40 (highly inadequate) in situations where all items are given a numerical value. Where one or more items were judged unratable, we gave it the average score of the remaining items.

Following the interviews, social workers recorded judgments about the appropriateness and probability of placement of patients outside the hospital. Later, the review panel reevaluated these judgments and made several other judgments about each patient. In this paper we will compare the SARS scores with these other judgments.

Results

Two of the areas of adjustment showed a large percentage of "unratable" responses (76% and 65%), namely "use of money" and "work assignments". Since the survey social workers had been brought in from the outside, they attempted to rate these items from the records, without much success. The questionnaires completed by relatives disclosed that only about half of the patients had any income, so that this may partly account for the sparsity of information found in their records concerning use of money. In the patient group for whom

ratable data were obtained, the results show a trend for patients to handle money poorly. For those few patients whose records did contain information about work assignments, most were rated as productive only if they received encouragement and supervision.

The remaining six adjustment areas, judged on the basis of social worker interviews and observations, showed a much smaller number of "unknown" ratings. A greater percentage of patients was rated as socially adequate in the areas of personal appearance and personal habits than in social group attendance, social group participation, responsibility for other patients and personnel, or in interpersonal relationships. It is clear that mental hospital patients perform more adequately in self-care activities than in those involving meaningful association with others.

Cross-tabulation of SARS scores with 13 background and examination items:

Of 13 background-examination items analyzed by cross-tabulations, the follow-

... a disproportionately large number of single patients was found to have scores indicating inadequacy.

ing showed no significant relationships to social adequacy ratings: (1) severity of neurological illness; (2) severity of medical-surgical illness; (3) sex; (4) race-ethnicity; (5) whether patient had ever been on furlough; (6) ratings of strength of current ties to persons outside the hospital; and (7) the social worker's estimate of chances for discharge.

An interesting relationship was found between the social adequacy scores and the presence or absence of a criminal commitment in that the 20 patients under criminal commitment tended to cluster at the adequate end of the SARS. This suggests that

these patients were possibly being held in the hospital because of their criminal commitment and not because of their psychiatric status. The social adequacy scores showed the expected relationship to the reviewing psychiatrist's choice of appropriate

discharge prospects and obstacles, family attitudes, etc. On the basis of preliminary studies, we selected six questionnaire items for comparison with social adequacy ratings. Again, these comparisons were done by cross-tabulations.

This finding lends support to the position that many mental hospital patients do not necessarily need hospitalization.

placement for the patient. The patients who scored at the adequate end of the scale were most often judged appropriate for release to their own care or to outpatient care, whereas those with inadequate scores tended to be judged appropriate for closed wards, other types of hospital care, or nursing homes.

The SARS scores also showed all the expected associations with psychiatric diagnosis and severity. Patients with mild chronic brain syndromes or mild psychoses tended to have adequate scores whereas the opposite was true for those patients with severe disorders. Social inadequacy tended to increase with both age and length of hospital stay. There was a strong relationship between the social adequacy level of patients and their hospital status at the one year follow-up.* Those patients who had been scored in the inadequate range tended to be in the hospital one year after the date the sample was drawn, and those whose scores fell at the "adequate" end of the scale tended to have been discharged within 90 days following the sampling date.

Cross-tabulation of SARS scores with six family questionnaire items:

Families of survey patients were sent a questionnaire requesting history data, judgments concerning present patient status,

Only one of the six items turned out to be unrelated to social adequacy ratings, and this was the relatives' answer to: "What extra help would you need before you would be able to care for the patient at home?" When the scores for social adequacy were cross-tabulated with current marital status, a disproportionately large number of single patients was found to have scores indicating inadequacy. On the other hand, patients who had been steady workers prior to hospitalization tended to be scored as socially adequate. Patients whose behavior prior to hospital admission was described as psychotic more often received scores indicating social inadequacy, whereas the opposite was true for patients who were described as nervous or anxious prior to admission. Those patients who were still interested in things at home (as judged by relatives) were more frequently rated by social workers as socially adequate than those who were not interested in things at home. A striking relationship was found between the patients' social adequacy scores and the respondents' attitudes toward their return home; as might be expected, respondents were more accepting of the return of the more adequate patients.

Three main placement categories and SARS scores:

One of the principal goals of this survey of resident state mental hospital patients was to obtain judgments on appropriate placement, that is, to determine where these

* One year after the original survey, a follow-up study was done to determine if the sample patients had been released or were still in the hospital.

patients could be treated or placed if suitable alternate facilities and programs were available in sufficient numbers. Several of the examiner groups made such ratings on the sample patients on the basis of their particular examinations and these were later reviewed, confirmed, or changed by the review panel on the basis of all data available.

Eleven different placement categories were used, but later these were combined into three larger placement groupings: (1) Release (to own care, to outpatient care, to halfway house or foster home); (2) Transfer (to nursing home, chronic disease hospital, general hospital, day hospital or night hospital); and (3) Retain (open or closed ward mental hospital care). The total number of patients judged suitable for these three main types of placement was as follows: (1) Release—25%; (2) Transfer—32%; and (3) Retain—43%. Since this survey is based on a large and representative sample of the current residents of a state mental hospital system, these findings indicate clearly that a majority of such patients could appropriately be placed or treated elsewhere if such facilities were available. When these three placement groups are tabulated against the social adequacy scale ratings, it is noteworthy that almost 46% of the patients designated as suitable for hospital release had scores ranging from 8 to 15 (highly adequate), while only 16% of the patients judged as suitable for transfer or for retention received comparable scores. Conversely, only 4% of the patients in the release classification had scores of 32-40 (highly inadequate) but more than a third of the patients in each of the other two categories had scores in this range. These results speak well for the validity of the SARS.

Comments and Conclusions

The Social Adequacy Rating Scale was

found to be a very satisfactory instrument when used to assess data gained through first-hand observation and personal interview. The scale did not work out well when used to evaluate patient behavior from hospital records, primarily due to lack of full or relevant information; staff social workers could probably have completed these ratings from personal knowledge of the patients.

Almost one-fourth (23.4%) of the total group of 1,537 subjects was rated as socially adequate or in the next best category (on a 5-step scale). This finding lends support to the position that many mental hospital patients do not necessarily need hospitalization. It may also mean that hospital treatment is effective and that scientific advances in psychiatric care can now reduce symptomatology, which in turn enhances effectiveness in social functioning for large numbers of patients.

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History

Looking Back

The National Association for Mental Health began in 1909 as the National Committee for Mental Hygiene and merged in 1950 with the Psychiatric Foundation and the National Mental Health Foundation to become NAMH. The following remarks were made by Lewellys F. Barker, M.D., President of the National Committee for Mental Hygiene on the occasion of the Committee's eighth annual meeting in 1916. They were reprinted in Volume I, No. 1 of MENTAL HYGIENE, January, 1917. We feel that the problems of yesterday speak to the problems of today. We phrase them differently and discuss the mental health of the "lower socio-economic groups" rather than of "paupers" or apply the label of "social breakdown syndrome" rather than "anomalies of feeling and abnormalities of behavior", but our purpose remains the same. Unfortunately, society's way of looking at these problems hasn't improved much, either. It is good for us to remember that we set out with a gigantic task in front of us and it remains to be accomplished.—THE EDITOR

THE WIDER FIELD OF WORK OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

TODAY I shall ask you to look for a few minutes at the wider field that this National Committee ought sooner or later to cultivate. Those most interested in the whole subject have had clearly in mind, from the time of establishment of the Committee, the fundamental principles that underlie mental hygiene in its wider sense. Writing four years ago of the scope of our work, I defined a campaign for mental hygiene as "a continuous effort directed toward conserving and improving the minds of the people; in other words, a systematic attempt to secure human brains so naturally endowed and so nurtured that people will think better, feel better, and act better than they do now"; and I stated that, broadly conceived, the general problems of mental hygiene are "first, to provide for the birth of children endowed with good brains, denying, as far as possible, the privilege of parenthood to the manifestly unfit, who are almost certain to transmit bad nervous systems to their offspring—that is to say the problem of eugenics; and second, to supply all human beings from the moment of fusion of the parental germ cells onward, and whether ancestrally well begun or not, with the environment best suited to the welfare of their mentality." The consideration of these two great problems, including, as they do, the influences of heredity on the one hand and of environment (physical, chemical, biological and social) on the other will point the way to concrete work for a National Committee like ours not only during our life-time but for centuries to come. We must begin by collecting facts; we must make these facts known to the people of the United States; and we must organize agencies through which the people may be helped in applying them.

Whatever work we undertake should be thoroughly well-organized, carefully planned in advance; once started, it should be continuously sustained. We must avoid making the mistake of engaging in work that we are not prepared properly to prosecute.

In 1912, I referred to a number of the problems the consideration of which might well, sooner or later, occupy our attention. Among them may be mentioned: (1) the marriage of people with psychopathic tendencies; (2) the relations of puberty, of pregnancy, and of the climacteric periods to mental hygiene; (3) the pedagogic problems connected with children presenting a lower degree of educability than normal; (4) the psychology of the adult criminal and the relations that exist between crime and mental disorder; (5) the psychiatric study of juvenile offenders; (6) the cooperation of psychiatrists with the best legal talent in the revision of law-codes; (7) the psychiatric study of inebriates, paupers, prostitutes, and sexual perverts and a consideration of their sources; and (8) the study of the conditions, hereditary or environmental, that lead to the less outspoken instances of social maladjustment, including those of the psychoneurotic patients that crowd our hospitals and sanatoria, and those of the large group of persons that, owing to anomalies of character and conduct, provide material for the news-columns of the sensational press.

One important task will be to bring conviction, first to medical men, and later to the general public, that anomalies of feeling and abnormalities of behavior are as much subject to natural laws as are disorders and defects of the intellectual processes. I have been more than once surprised to find that even neurologists and psychiatrists may sometimes be wanting in this insight; whereas they could readily understand and forgive intellectual defects, they assumed an entirely different attitude toward pathological emotions and the feeble or perverted will. Until our neurologists, psychiatrists and medical men generally come more into agreement concerning the affective life and the conative functions, the origin of motives and the explanations of conduct, we can scarcely expect the public at large to bring their ideas of responsibility, of the nature and purpose of punishment, and of the methods for opposing and preventing crime, into accord with the conceptions of modern psychiatry.



Jacob H. Friedman, M.D.

Assunta R. Spada, R.N.

A psychiatric training program for high school students assigned to a geriatric service

In October, 1967, the Geriatric Service at Bronx State Hospital, affiliated with the Albert Einstein College of Medicine, underwent a marked metamorphosis from a traditionally oriented custodial geriatric service into a community oriented, treatment-focused unit.^{1, 2} In November, 1967, Governor Nelson Rockefeller initiated the New York State Youth Opportunity Program. The main purpose of this program is to discourage dropping out from high school due to financial stress, as well as to initiate and encourage careers in the mental health field. The Bronx State Hospital grasped this opportunity and to date has employed 175 high school students.

These students come from the lowest income areas and are principally of Puerto Rican or Negro descent, and reside, for the most part, in the economically underprivileged and emotionally deprived areas of

Bronx County (a borough of the City of New York). They worked after school hours, including holidays, at \$1.60 an hour for a maximum of 28 hours weekly. Since September 4, 1969, due to budgetary difficulties of the State of New York, the students can now only work a maximum of 20 hours weekly. The number of hours is determined by their school curricula and their willingness to work. During the summer months, all who are able may be employed for 40 hours weekly. Sixty-three students have thus far been assigned to the Geriatric Service.

The students are recommended by the high school guidance and employment counselors and instructors in seven area high schools. Miss Spada screens each potential trainee to determine his suitability for placement in the Geriatric Service. Only a few of the students were interested in nursing, clerical training or a trade. The majority did not know what they wanted except for the \$1.60 an hour. The supervisor of the program, in each of the respective high schools, visited the hospital and observed the program's progress. Miss Spada, in turn, visited the high schools for

Dr. Friedman is Clinical Director of the Geriatric Service, Bronx State Hospital, and Assistant Clinical Professor of Psychiatry, Albert Einstein College of Medicine, Bronx, N.Y. Miss Spada is Coordinator of the Youth Opportunity Program at the hospital. Requests for reprints should be addressed to Dr. Friedman at 1749 Grand Concourse, Bronx, N.Y. 10453.

necessary conferences. The students are trained in practical nursing care techniques (except dispensing medication), recreational and occupational therapy, with attendance at group sessions and therapeutic community meetings.

Miss Spada realized that these students must have insight into their duties, rather than merely learning to perform perfunctory routine services. She consulted with Dr. Friedman, who at the time was giving lectures on psychopathology to the afternoon and night shift attendants. It was agreed to have continuing didactic lectures for these high school students, three times weekly, one hour each session. Dr. Friedman and Miss Spada compiled a 34-page syllabus* of the following topics: An Introduction to the Field of Geriatrics; The Rejection of the Geriatric Patient in Our Western Culture; Methods of Admitting Patients to the New York State Mental Hospitals; The Mental Examination of a Patient; The Organic Brain Syndrome with Psychosis and Without Psychosis; Definition and Types of Delusions, Hallucinations and Illusions; Mental Mechanisms; Types of Depression; Suicide; Types of Therapy Employed on the Geriatric Service; and lastly, The Ten Commandments for Geriatric Nursing. Case presentations selected by the students are employed to illustrate these lectures. The students are encouraged to ask questions, especially in relation to their patients. It was believed that these high school students would not be able to grasp the principles of psychopathology in view of their meager education. A written examination on these topics, at the conclusion of six months, was

given. Surprisingly, not one student failed, the passing grade being 75%.

A therapeutic community meeting, solely for the students, is conducted by Dr. Joyce Strachan, twice weekly, one hour each session. The students desire information as to their own problems, such as knowledge of the female reproductive system, venereal disease, pre-natal care, childbirth, etc. These sessions are enthusiastically received. In addition, Dr. Friedman has seen a number of students in regard to minor emotional problems because of adverse home conditions. Principally because of the didactic lectures, the therapeutic community meetings and the general milieu of the hospital, these students have become very enthusiastic workers. While being trained in the Geriatric Occupational Therapy Department, ten students became unusually interested in the special Sensory Training Program,³ under the supervision of Mrs. Leona Richman, Occupational Therapist. The goal of this program is to increase sensitivity and to discriminate between environmental stimuli, through the animation of the sense receptors. Four students have become very interested in Reality Orientation Therapy,⁴ under the supervision of Muriel Oberleder, Ph.D., and these students conduct sessions in which the patient is made aware of his surroundings, through improvement of orientation, memory defect, retention and immediate recall, and general knowledge. The students also take an active interest in the evening recreational program. Mr. Ken Williams, the recreational instructor, states that the students bring the patients to the recreation activities; they help to motivate the patients by active participation and keep the patients alert and interested, all making for a moving session.

Our results have been considered remarkable. It must be stressed that these students

* Copies of this syllabus may be obtained gratis from Mr. Andrew Gill, Coordinator of the Youth Opportunity Program, Office of Manpower & Training, New York State Department of Mental Hygiene, 44 Holland Avenue, Albany, N.Y. 12208.

come from economically deprived, impoverished homes, as well as the slum neighborhoods of the Bronx. Of a total of 63 students thus far assigned to the Geriatric Service, 30 have completed their training program, having been graduated from high school. Of these 30 students, seven will study nursing. Seven obtained positions in local nursing homes as attendants; three remained at Bronx State Hospital as attendants; one is studying at Morrisania Hospital, Bronx, N.Y., to be an X-ray technician; six were referred to the Career Development Program for placement in full-time positions as psychiatric aides in mental health facilities; two married, one of whom is employed as a clerical worker in private industry and the other is a housewife. Twelve were compelled to leave the program as it interfered with their school work; they will return as soon as feasible. Three students were terminated as their work was considered unsatisfactory. Eighteen students are still participating. Surprisingly, the caliber of the school work has improved, despite their work after school. A typical example is the case of S.P., who was a school problem with poor grades, although above average intelligence. She had been treated in a mental hygiene clinic from the age of eight to ten years. She did not socialize and was unable to make or keep friends. She entered the Youth Opportunity Program because of poor economic conditions. Interestingly, her school grades improved despite working 24 hours weekly at the hospital. She always had felt inferior and insecure. Now she knows she can help people. Her only explanation is that she "found herself". She decided that after the completion of her academic course, she will enter college and become a registered nurse.

This program has been received with much enthusiasm by the various high schools. However, due to budgetary limitations, we must regrettably reject at least fifty percent of the applicants, and at present we are limited to 20 students at any one time, assigned to the Geriatric Service. The Board of Education of the City of New York, through the efforts of Mrs. Rynita Coram, Nursing instructor in Home Economics and Occupational Education, at Evander Childs High School, has given high school credit to the students who participate in this program. As a result of this extra credit, three students were able to graduate. To date, four schools are giving credit for work experience in our program. The remaining schools are expected to follow a similar policy. We feel our program has not only benefitted the recipients educationally, socially and personally, but will also contribute to the recruitment and expansion of much needed personnel in the health field. Other mental health facilities can easily apply our type of program in this humane endeavor.

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Elliot W. Williams, M.A.

From Psychiatric Aide to Psychologist

Eleven years ago I faced two questions: 1. Could I as a long term career psychiatric aide attain the necessary education to qualify as a psychologist in the Illinois Department of Mental Health? 2. Would I as a psychologist be adequately accepted by professional and non-professional staff as well as the patients.

The first question had to be answered before the second one would even be relevant. Though I had a family to support and was approaching my fortieth birthday, I was persuaded by a local philosophy professor to enroll in a summer course in psychology at MacMurray College which is near the hospital. It was hard to get back to a routine of books and study. Twelve years had elapsed since I had completed my A.B. degree as a G.I. student in a southern college.

After summer school I went on to a variety of psychology courses. I worked on a straight night shift at the hospital and took one or two courses during the day. Study was done in the evening between sessions of changing diapers and other duties in connection with looking after a new baby. I made use of every spare minute of marginal time. My books were

always under the seat of the car ready to be used if any time had to be spent waiting, such as at the grocery store or coin wash.

At times I grew very discouraged and felt like abandoning the idea and resigning myself to a permanent career as aide supervisor. This was a job I enjoyed and had been able to perform with satisfaction. Fortunately I was strongly encouraged by my instructors at MacMurray College and the chief psychologist at the hospital to carry on with my studies. In June, 1963, after four years of hard work and study, I received an M.A. degree in psychology.*

Now I faced the second question which had bothered me for four years. Would I, after fourteen years of service in this hospital, be able to shift into the role of a clinical psychologist and be adequately accepted by professionals, nonprofessionals and the patients. Stanton and Schwartz⁶ had told of the sharp lines of distinction separating professional from nonprofessional staff by a "prestige hierarchy" in a mental hospital. Dunham and Weinberg⁸

* For the first two years I paid my own expenses. I learned that aides might be eligible for employment education grants from the state. This was considered a rare practice, but after some time my application was approved. Tuition costs for the last two years were paid by the State Department of Mental Health.

Mr. Williams is a psychologist at Jacksonville State Hospital, P.O. Box 131, 1201 South Main Street, Jacksonville, Illinois 62650.

tell of the employee class hierarchy at a state hospital which placed the aide on the "last rung of the social ladder", just above the patients. My own experiences seemed to indicate that patients were rated considerably higher than aides in social acceptance by some of the professional staff. On the other hand, we had a number of professionals who were very progressive and democratic in their acceptance and encouragement of the psychiatric aides. It was evident to me that our hospital had a "prestige hierarchy", though less absolute than some in other institutions. Could I cross over into this structure and gain acceptance without being totally rejected by my former peers in the aide group?

Though I agree with Ellis⁴ that one does not have to have one hundred percent approval by his associates, there is considerable evidence that an employee does have to have considerable support and approval from fellow workers to avoid role failure. Cumming and Cumming² tell of sanctions imposed on a psychiatric aide by her peer group after she had received a "status sign" by being elevated into a special job with more favorable hours. Goode⁶ stresses the need for conformity to group norms and tells how sanctions by others may be used to force this.

Several professionals and some of my aide associates seemed to recognize the problem I might face in changing roles at the hospital. One aide friend suggested that I transfer to another hospital.

Finally I was encouraged by the chief psychologist, Martin Cohen, to go ahead and enter the intern program. He acknowledged that my situation was somewhat unique, but that it should be given a fair trial. His unwavering support was most appreciated because I was really in no position to transfer to another location. My brother, a psychiatric patient at the hos-

pital for 13 years, had just been discharged to me and needed to remain near the hospital for outpatient and occasional inpatient treatment.

Though I had to accept a sixty dollars per month reduction in pay to move from aide supervisor to intern psychologist, I was able to borrow money and finance my family during this year of training. After passing the civil service examination in Springfield I accepted an offer from the chief psychologist to work as unit psychologist on the Medical Surgical Geriatric Complex. There I would have to work with many aides, nurses and physicians who had known me for years in the role of psychiatric aide supervisor.

Fortunately, physicians, social workers, psychologists, and particularly the aides, showed a great deal of patience, and I was able to carry out my duties with satisfaction and make some professional growth at the same time.

Most of the patients accepted me very well in the new role. However, some of the older ones who had known me for a long time found it hard to visualize me in my new role.

Five years on this unit as a psychologist have been very educational and rewarding to me. What moderate success I may have had in making this transition in roles has been largely due to the support and encouragement I received from the chief psychologist along with the professional and nonprofessional staff of the hospital. Without their acceptance and forbearance role failure would have been inevitable.

It is my feeling that psychiatric aides would now find it less difficult to accomplish upward advancement and role change, due to recent progressive developments in the mental health profession. The psychiatric aide has emerged as a mental health professional in his own right. Carkhuff and

Truax¹ reported that aides with brief training developed into effective lay counselors. Ellsworth⁵ conducted a study to show how the aide's role could be enhanced to make him very effective as a treatment agent. Pratt and Tooley⁷ mention the breakdown in the old professional-nonprofessional dichotomy. In my first published article⁹ I mentioned that distinctions between these same groups have been abolished. Career ladder plans to insure aides and other employees opportunities for upward mobility are now under study in Illinois and other states.

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Law, Society and Mental Illness

Reprint from the January 1970 issue of *MENTAL HYGIENE*. \$1. Includes following list:

Community mental health and the criminal justice system, Shah;

Development of community mental health programs in the civil area; Woloshin and Goldberg;

Titicut follies revisited: a long range plan for the mentally disordered offender in Massachusetts, McGarry;

New York's mental hygiene law—a preliminary evaluation, Zitrin, Herman and Kumasaka;

Who is competent to make a will?, Weihofen and Usdin;

A radical view of social welfare and mental health, Ginsberg.

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M. K. Distefano, Jr., Ph.D.

Margaret W. Pryer, M.A.

Stability of Attitudes in Psychiatric Attendants Following Training

The empirical investigation of attitudes and attitude change among hospital personnel remains a relevant issue in mental health research especially in the evaluation of both training programs and hospital treatment programs. The most promising research instrument used to measure such attitudes still appears to be the "Opinions About Mental Illness" (OMI) scale developed by Cohen and Struening.¹

The factorially derived OMI consists of 51 Likert-type items that measure five dimensions of attitudes toward mental illness:

A. Authoritarianism—a view of mental patients as an inferior, threatening out-group requiring coercive handling.

B. Benevolence—a humanistic viewpoint that the mentally ill must be dealt with in a kindly, paternalistic manner.

C. Mental Hygiene Ideology—a positive orientation toward the mentally ill which accepts modern mental hygiene concepts.

Dr. Distefano and Mrs. Pryer are in the research department of Central Louisiana State Hospital, Pineville, Louisiana 71360.

The authors wish to express their appreciation to Mrs. Mary Poe, Chief of Nursing Services, and to Miss Bobby Downa, Mrs. Stella Craig and Mrs. Dorothy Lary of the Training Department of Central Louisiana State Hospital for their cooperation during this study.

D. Social Restrictiveness—a view of the mentally ill as constituting a threat to family and society and requiring restriction in functioning during and after hospitalization.

E. Interpersonal Etiology—a viewpoint reflecting the belief that mental illness arises from interpersonal experience, especially parental love deprivation during childhood.

Developed originally from the factorial validity model, the OMI has been demonstrated to be related to performance evaluations of psychiatric aides⁴ and to overall hospital effectiveness.² In previous studies, the authors of this scale and other independent investigators^{3, 5} have raised a major research issue regarding the extent to which mental health attitudes can be changed.

A recent study by Pryer, Distefano, and Marr⁶ compared the effects of training and short-term experience on attitude change among psychiatric attendants using the OMI scale. These investigators found that experience alone in the hospital did not influence OMI attitudes but that psychiatric aide training did effect change in certain attitudes. OMI scales given before and after a five-week training program to 39 newly employed aides revealed significant

increases in **Mental Hygiene Ideology** and **Interpersonal Etiology**. Twenty-five experienced aides who had not had prior training were given the OMI both before and after their participation in the same type basic training program. Significant increases after training were obtained on the two attitudes found significant in the other training group and, in addition, a significant decrease in **Social Restrictiveness** was noted. **Authoritarianism** proved resistant to change in both training groups.

The purpose of the present investigation was twofold: 1. To replicate with a similar but larger sample of aides the phase of the previous study⁶ involving changes in OMI attitudes of newly hired attendants after training; and 2. To follow up a sample of new attendants after training to determine the stability of OMI attitudes over periods of six months and one year.

Method

All subjects in the present research were newly hired, first-level psychiatric attendants at this hospital. The replication study group consisted of 71 newly hired attendants, none of whom were included in the previous study. OMI scales were administered both immediately before and after training to this group.

The same introductory training course was given to all aides immediately after being hired. This training consisted of a five-week, full-time (40 hours per week) introductory course in psychiatric nursing including both classroom work and supervised clinical experience on selected wards.

Results and Discussion

Attitude Changes Immediately After Training

For the replication phase of the study, before and after training measures on the

OMI were compared (correlated t-tests) for 71 newly hired psychiatric attendants. No statistically significant changes in **Authoritarianism** were obtained. However, significant "desirable" changes were found for the remaining scales. After training, attendants were found to score higher in **Mental Hygiene Ideology**, **Interpersonal Etiology**, and **Benevolence**, and significantly lower in **Social Restrictiveness** (all t-tests significant at .01 level).

The after-training increases in **Mental Hygiene Ideology** and **Interpersonal Etiology** were consistent with the findings of Pryer, *et al.*⁶ Changes in **Benevolence** and in **Social Restrictiveness**, which were in the expected direction in the previous study, were found to be statistically significant in the present study.

Stability of Attitudes Following Training

OMI scores of 48 psychiatric attendants after training were compared with scores on the same attendants tested six months later (correlated t-tests). Results revealed no statistically significant changes on any of the attitude factors six months after training.

OMI scores of 22 psychiatric attendants were studied immediately after training, 6 months after training, and 12 months after training. A repeated measures simple analysis of variance (treatment x subjects analysis) revealed no significant changes on any of the attitude factors during the followup period.

While results of the present research support the position that certain attitudes are amenable to change during initial aide training, they also offer evidence that the changed attitudes tend to remain stable at 6- and 12-month intervals after training. Of perhaps equal significance is the consistent absence of any substantial reduction in **Authoritarianism** during training and the

lack of evidence of any substantial change in this attitude dimension during the subsequent year of employment.

Conclusions and Implications

The present research offers further evidence that certain mental health attitudes measured by the OMI are amenable to change through training. **Authoritarianism** has been found consistently resistant to change and **Mental Hygiene Ideology** and **Interpersonal Etiology** have been found consistently amenable to change. Existing evidence suggests that **Social Restrictiveness** and **Benevolence** also may be changeable through training programs. The potential impact of training on OMI attitudes is particularly important since these attitudes have been found related to rated aide job performance and hospital effectiveness. A significant finding of the longitudinal follow-up in the present study was that OMI attitudes appeared to remain stable 6 and 12 months after training, which suggests that initial attitude gains made through training are maintained for at least 12 months. Thus, these attitudes may be suffi-

ciently stable over time to be of considerable value in a variety of mental hospital research programs. Such attitude measures among hospital personnel would seem useful to include in evaluating treatment programs especially in those hospitals where change is being implemented in the direction of decentralized, specialized programs geared to meet the individual needs of various types of patients. Evaluation of such programs may reveal that certain attendant or staff attitudes are directly related to therapeutic outcome in some types of patient programs but not in others.

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Milton Mazer, M.D.

Psychiatric Disorders in Young Women: The Public Health Implications

Introduction

In a study⁷ of all admissions to a psychiatric service by the population of an island community over a five and a half year period, the highest rates were found in females aged 25-34 years of age. The mean rate of first admissions per year for all psychiatric disorders was 33.2 per 1,000 women in that age group and during the five and a half year period of the study, more than 18 percent of all women in that age group had been seen by a psychiatrist. A number of other studies^{1, 2, 5, 6, 11} have also shown that females in this age group come for psychiatric treatment more frequently than any other age group in either sex. Since so large a proportion of women in this age decade reached a psychiatric facility, the public health implications of this finding were arresting.

This paper gives data on diagnosis, marital status, social class, type of preg-

nancy, in- and out-migration, and the number of their children for all women, 25-34 years of age living on an island who consulted a psychiatrist during a five and a half year period.

Since these women were largely engaged in the rearing of young children, the possibility that psychiatric intervention might improve disturbed mother-child relationships marks them as a strategic group for concern.

Population and Locale

The locale of the study is an island lying seven miles by boat off the coast of a New England state. The population was 5,959 on January 1st, 1965, as determined by a special census. Out-migration is of the same magnitude as in-migration; the largest age group leaving the island are those graduating from high school, of whom approximately 80 percent leave the island each year. The age groups 20-24 and 25-29 are smaller than the 15-19 year group. As the result of in-migration, the 30-34 year age group is of the same magnitude as the 15-19 year age group. Because of the seasonal nature of the economy and the lack of industry, income is low.

Dr. Mazer is Director of the Martha's Vineyard Guidance Center, P.O. Box 634, Edgartown, Mass. 02539.

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Method

The data described in this report were collected as part of the maintenance of a psychiatric-parapsychiatric register⁸ by the island's community psychiatric clinic. All but one of the patients were observed clinically by the author; the exception was treated by a psychiatrist on the mainland. The data collected were analyzed in relation to psychiatric condition, marital state, social class position, migration status, the incidence of unconventional pregnancies, other presumptive stressors, and the number and ages of the children in the care of the patients. The clinical records were scrutinized for information on additional possible stress factors.

Findings

Diagnoses. Fifty-four young women sought help. Excluding the six categorized under "marital problems", who were not themselves considered to be suffering from a psychiatric disorder, two-thirds of the 48 remaining women had psychoneurotic disorders. Depressive reactions made up 42 percent of all psychiatric illnesses and 61 percent of the psychoneurotic disorders. Two of the women suffered from alcohol addiction, and two from schizophrenic reactions. Thus, they suffered from psychoneurotic reactions generally and from depressive reactions specifically in a much larger proportion of instances than the island's population at large.⁷

Marital Status. Data were available on the marital state at the time of admission of the 48 females with psychiatric illness and the number of females in each marital state in the population on January 1, 1965 in the same age group. The rates for psychiatric disorder over the 5½-year period were lowest among the married (158/1000), somewhat higher among the never married

(217/1000), and very much higher among the divorced and separated (583/1000). A similar lower rate among married persons was also found in this community in a study of psychiatric patients in general practices.⁹ However, only the differences between the currently married and the divorced-separated were statistically significant.

Social Class Position. The social class position of 47 of the 48 patients and 258 of the 263 women in the general population in the 25-34 year old age group for whom such data were available were compared. The criterion used for social class position was the occupation of head of household. Both patients and all females in the general population were categorized by one of Hollingshead's⁸ seven categories. The use of occupation alone as a measure of social class position has been shown by Hollingshead and Redlich⁴ to have a high correlation with the composite score using residence, occupation, and education. Because of the limited numbers available, Hollingshead's categories were collapsed into two groups, I-IV and V-VII. The risk of becoming a psychiatric patient was not significantly different for the two social class groups.

Migration. The data show that 8 of the 48 patients (17%) had migrated to the island within the year of admission as compared with only 13 of the 262 (5%) women in that age group resident on the island at the time of the 1965 census. In short, there appeared to be a significantly higher rate of recent migration to the island in female psychiatric patients than in all females in this age group. Similarly, Nielsen¹⁰ on the Danish Island of Samsø found a higher psychiatric admission rate for those born off the island than on it. A very high rate of out-migration also appeared to be a characteristic of this group of female psychiatric patients.

Type of Pregnancy. Eighteen of 38 women who had ever been delivered of a child, or 47% had had their first child conceived while unmarried. Of 101 children alive at the time of admission of their mothers, 27.7 percent were the result of pre-marital, non-marital, or extra-marital conceptions. When "unconventional" pregnancies are related to place of birth it is seen that 14 of 19 ever-delivered island-born women as compared to 7 of 19 ever-delivered mainland-born women had had such experiences, a difference which is statistically significant at the 0.01 level. Since the mainland-born women came largely from larger towns or cities, the difference in the two groups may simply reflect a cultural characteristic, namely, the generally higher rate of pre-marital pregnancies among rural people.

The incidence of pre-marital pregnancies in the general population in this age group was determined from a comparison of marriage dates and dates of birth of first-born children. Of the 17 island-born psychiatric patients who had had either pre-marital, non-marital or marital pregnancies, 12, or 70.6 percent, had had "unconventional" pregnancies. Of the 69 non-patients in that age group born on the island for whom data were available, 29, or 42.0 percent, had had "unconventional" pregnancies. The difference between the two groups is significant at the 0.05 level. It can be concluded that the occurrence of "unconventional" pregnancies was significantly more frequent in the patient group than in the non-patient group.

Other Presumed Stress Factors. Six of the patients were pregnant at the time of admission. Three women had been delivered of an infant within 4 months. Five of the women had experienced a death of a parent, brother, child, or ex-husband in recent weeks or months. Three of the women, though they desired children, were involved

in a sterile union; two of them later adopted children.

Children in Maternal Care. Data on the number and ages of their children were analyzed. The 38 women who had ever been delivered of a child had a total of 101 children. Seventy percent were 7 years or younger and 95 percent were below the age of 12.

Summary

The entrance into a period of psychiatric treatment by these women, was considered of particular interest from the point of view of the public health because of their high incidence of admission into treatment and the large number of young children in their care. In brief, 94 percent came to treatment because of psychoneurosis or personality disorders. The data showed a higher rate of divorce and separation among patients than among women in the same age group in the general population. A surprisingly high rate of "unconventional" conceptions (non-, pre-marital) was found in all women in this age group, with a higher rate in those who became psychiatric patients. Notable among positive findings was a high rate of in and out-migration of the women who came to psychiatric treatment. It was found that 19 percent of the patients were either pregnant or had been delivered of a baby within six months prior to admission and an additional 10 percent had experienced the death of someone quite emotionally close to them within days or months before coming to treatment.

Since the psychiatric disorders in this group of women tended to be of the more benign types, and since many of them came for treatment soon after a presumed stress experience, it would appear that the investment in therapeutic resources for their care may not have to be as great as in other age groups. It is probable, therefore, that the

treatment of this age group of young women caring for a significant number of children can be among the most productive efforts of mental health resources.

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Lawrence H. Tuft, B.A.

Merrill I. Berman, M.D.

Men of the Sea

A description of a psychiatric population of merchant seamen using the M.M.P.I.

"The wonder is always new that any sane man can be a sailor—"

R. E. EMERSON

Introduction

The main literature dealing with psychiatric disorders among merchant seamen was written during or immediately after World War II and was concerned with war-connected situations and trauma. The bulk of this is of a descriptive nature, apparently obtained by impressions and observations in clinical settings.^{1, 2, 3, 4, 5, 6} In a review of cases at Merchant Marine rest centers, Powdermaker⁶ describes the seaman as appearing "to select his occupation because it provides a situation in which he can find satisfaction and avoid loneliness, responsibilities and close emotional ties which are intolerable to him." This seems to still apply to the population we deal with in our psychiatric setting in a Public Health Ser-

vice Hospital, where the seaman not only sails away from home and family but also engages in transient and non-permanent relationships through drinking and alcoholic mis-adventures and prostitutes. In a study of the characteristics of 500 wartime merchant seamen, Kubie⁴ indicates similar trends along with extreme diversity in biographical data. The purpose of the present study is to investigate the characteristics of a psychiatric population of merchant seamen admitted to our 18-bed inpatient unit within a general hospital in the PHS Hospital in San Francisco. The M.M.P.I. was used as a personality inventory in order to facilitate further research and to use as an objective template to relate clinical data and impressions into clearer understanding. We also attempted to define the merchant seamen as a biological subsystem operating within a larger maritime system for meeting his needs. The need for money vis-à-vis the shipping system, security vis-à-vis the union system and the PHS Hospital system for health needs and "A port in a storm" is well known, but not yet documented. In general, the merchant seaman is a dependent, vulnerable human manipulated by more powerful and complex systems such as the unions and shipping companies.

Mr. Tuft and Dr. Berman are with the Public Health Service Hospital at 15th Avenue and Lake St., San Francisco, Calif. 94118 where Dr. Berman was Assistant Chief of Psychiatry.

The views expressed in this paper are those of the authors and do not represent the U.S. Public Health Service.

Method

The sample consisted of 40 Merchant Marine psychiatric inpatients, the total number of merchant seamen admitted to the psychiatric service over a four month period at the PHS Hospital in San Francisco. They were representative for age, marital and familial background, and union membership for our usual inpatient and outpatient population and covered the spectrum of psychiatric diagnostic categories.

The Minnesota Multiphasic Personality Inventory^{2,7} was administered on admission and scored using the standard 13 scales and 31 sub-scales. The M.M.P.I. was chosen because of ease of administration, standardization, and availability of objective data. The 31 sub-scales were derived from a typical psychiatric population at Langley Porter Neuropsychiatric Institute.⁷

lence of feelings of isolation from other people, a lack of belongingness and gratification in social situations and familial discord. These findings fit very well into the clinical material which consistently showed our patients to be manipulative, dependent yet fearful of close involvement and other factors such as the consistent tendency to never refer to one another by name, a great competitiveness for one to one staff-patient relationships which were mainly of a manipulative (psychopathic) nature, and the denial of feelings of loneliness by use of bravado (i.e., drinking and sexual prowess).

Depression was the next most significant whole scale and the second highest scale; however, this elevation seems quite normal or predictable for any psychiatric population and coincides with the clinical appraisal of low self-esteem, feelings of hopelessness, helplessness, and despair. The

Paranoia was also a relatively significant scale.

The M.M.P.I. was administered to the patients within the first few days after admission to our open-door therapeutic community. It is the feeling of the investigators that the value of the M.M.P.I. is in its ability to measure response tendencies on a continuum. Results were useful in helping to clarify diagnosis in certain cases.

Discussion

The data does indicate that there are some scales in which merchant seamen respond more cohesively than others, as compared to a general, non-merchant marine psychiatric inpatient population.⁷

The most significant whole scale score was on the psychopathic deviate scale. The mean is fairly high for a population with a mean of 41 years of age and an SD of 10. The most significant sub-scales indicate a preva-

lence of feelings of isolation from other people, a lack of belongingness and gratification in social situations and familial discord. These findings fit very well into the clinical material which consistently showed our patients to be manipulative, dependent yet fearful of close involvement and other factors such as the consistent tendency to never refer to one another by name, a great competitiveness for one to one staff-patient relationships which were mainly of a manipulative (psychopathic) nature, and the denial of feelings of loneliness by use of bravado (i.e., drinking and sexual prowess).

Depression was the next most significant whole scale and the second highest scale; however, this elevation seems quite normal or predictable for any psychiatric population and coincides with the clinical appraisal of low self-esteem, feelings of hopelessness, helplessness, and despair. The

sub-scales indicate that complaints about physical malfunctioning, preoccupation with oneself, brooding, ruminativeness, and irritability were more prevalent than more socially oriented ways of showing depression. Paranoia was also a relatively significant scale. The sub-scales indicate ideas of external influence, externalization of blame for one's problems and persecutory ideas which fit quite readily with clinical data. The elevated psychesthesia score indicates a relatively high degree of phobias and compulsive behavior. However, much of this scale's elevation may be seen in terms of the elevated schizophrenia score. Schizophrenia is the highest scale and the most frequent over-all clinical diagnosis. The most significant sub-scales indicate sensorimotor dissociation, feelings of depersonalization, withdrawal, along with feelings of

not being in control of one's impulses. Clinically, the patients tended to emphasize the need for control of feelings and fears of loss of control. Anger was seen as

Feelings of pressure for action and a callousness towards one's own motives and those of other people are quite prevalent.

an all-or-none phenomenon. One either showed anger and was completely out of control and killing, or one withheld all such feelings and kept rigid control of such feelings lest they erupt as a volcano of violence or overt psychosis and/or self-destruction. Frequently, these rigid controls were dissolved with alcohol. The use of alcohol, also prevalent among seamen, represents a system sanctioned method of losing control without being held responsible.

Although hypomania is not unusually high, the sub-scales indicate that feelings of pressure for action and a callousness towards one's own motives and those of other people are quite prevalent. This would also correlate with the psychopathic deviate scale and lack of guilt feelings. The low level of hypochondriasis in this population may suggest that these patients have not been able to adapt such behaviors as a rationale for obtaining dependency gratification, as compared, possibly, to a medical-surgical group of seamen. In general, the results of the present study generally support the findings of the earlier studies cited. The merchant seamen psychiatric patients tend to have rather poor interpersonal relationships which result in a general inability to invest emotions in other people in a trusting relationship. There is also an implication of a fear of involvement, for intimacy may result in destruction, engulfment, or elicit fear of homosexual panic. The findings also indi-

cate a great deal of potential for overt schizophrenic breaks with psychopathic coverups and suggest that many non-adaptive behaviors occur (in the general society) but the Merchant Marine system sanctions behaviors that are adaptive both to ward off complete disintegration and to enable the seamen to identify with group expectations and norms, a protection from the subjective feeling of being alone and desolate yet feeling a need for connection with his fellow man.⁸

Conclusions

Forty Merchant Seamen psychiatric inpatients were given the M.M.P.I. and were compared on 44 scales. The results indicate that distrust of interpersonal relationships is the main characteristic of these patients with implications of fear of exploitation and homosexual panic from clinical data. Clinically, it seems that when their defenses crumble, the underlying schizophrenic symptoms with paranoid ideation, blaming of others, and general projection of hostility onto outside influences is seen while when re-integration occurs in the therapeutic community, one sees more manipulative, psychopathic superficial behaviors with denial of dependency interfering with more therapeutic adaptive modifications. These recuperative measures are adaptive to the merchant marine-union system but do not allow for psychotherapeutic relationships to develop as the patients can easily re-constitute and ship out, fitting back into the marine system. The data suggests more need for correlations on age, siblings, sibling order, marital status, family history, deprivation, abandonment, losses, etc. The question is also posed—Is this the result of being a seaman or would personalities like these gravitate towards shipping? The union system seems to offer the most consistent source of contact with one's fellow-

man, a sense of identity and a good potential resource of supporting fragile self-esteem and a consistent self-concept and identity. It is also suggested that the M.M.P.I. can be a useful adjunct in the diagnosis and clarification of personality tendencies in such a patient population. We would next like to compare this group to a medical and/or surgical population of merchant seamen as well as a non-patient merchant seamen population.

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Allan H. Cristol, M.D.

We need sheltered workshops for former mental patients

The author compares job performance of a group of 100 chronic schizophrenic patients and 100 non-schizophrenic clients at a sheltered workshop. He concludes that there is a great need for terminal sheltered workshops for chronic mental patients.

This paper will review some of the experiences of one hundred chronic patients subsequent to their discharge from various hospitals, and offer some suggestions about their employment. Chronic mental patients possess certain describable traits. They frequently are labeled chronic schizophrenics by the hospital. Often, they have been in the hospital five, ten, and even twenty years at the time of discharge. Some of this group demonstrate bizarre delusional systems, but often keep these ideas to themselves. Many are quite dull intellectually, and there is high incidence of functional illiteracy among this group of people.

Some had lost touch with their relatives prior to their hospitalization, while many others had lost touch during the long period in the hospital. It is this alienation from anyone living outside the hospital community which has, until recently, been a major factor in their long stay in the

hospital. There has been no place to which these patients might return upon discharge from the hospital.

Another important characteristic of this group is its vocational history. In general, the patients had had very little work experience prior to being hospitalized. Usually this work experience was unsuccessful. Most of what these patients attempted—school, work, and socialization—was unsuccessful. Although it is difficult to be sure why these failures occurred, the withdrawal and bizarreness can often be traced back to the patients early history, and would cause them to do poorly in school. Some patients suffer from a primary defect in capacity.

The Current Discharge Procedure

Since these chronic patients have no home in the community to which they can return, homes are being created for them. In the author's community, for example, patients are sent to certain boarding homes where large groups of them live together. These homes are owned by resident land-

Dr. Cristol is an assistant professor, Department of Psychiatry, Temple University Health Sciences Center, Broad and Tioga Sts., Philadelphia, Pa. 19140 and serves as a psychiatric consultant to Goodwill Industries of Philadelphia.

who receive instructions from the hospital personnel to facilitate their dealings with their tenants. Staff employees from the mental hospital visit the former patients on a regular basis for discussions, and they are maintained on anti-psychotic drugs which are prescribed by the hospital and which do not cost the patients anything. This supervision lasts about one year from the time of placement. The landlady receives the major portion of the former patient's welfare or social security check to cover the cost of room and board. The boarding house life contains virtually nothing in the way of activities or responsibilities for the patients, but boarders are free to come and go as they like within the community. What has happened is that these patients have been shifted from a large public institution, the mental hospital, to a small private institution, the boarding house.

Under current practices, many of the former patients, while living at the boarding homes, are sent to sheltered workshops, such as Goodwill Industries in Philadelphia where the author is psychiatric consultant. An outline of the program and its results will bring out more clearly the main point of this paper which is that it is extremely difficult to make job placements in competitive industry for this group of former patients. A realistic alternative would be an extensive terminal sheltered workshop.

The Goodwill program offers a twenty week evaluation for clients with either primarily physical or primarily psychological problems. The client receives physical, psychological, and psychiatric examinations concomitantly with assignment to various work samples. Depending on recommendations based on the various evaluations and on his own interests, the client is then assigned to one or several areas of the Good-

will factory or to one of the Goodwill stores. At the end of the twenty weeks, he may be sent to a specialized school such as a business college or beauty culture school, employed in competitive industry, hired by Goodwill, or terminated as a program failure.

Outcome of One Hundred Schizophrenia Clients in Goodwill Program

Of the last one hundred clients who have been diagnosed as chronic schizophrenic by the author (these are the chronic hospital patients described earlier) three (3%) have been referred for skilled training which could lead them to fairly high level competitive employment. Eighteen (18%) were placed in low level jobs such as clerical worker, custodian, food service worker, and packer. These jobs are slightly above sheltered workshop in terms of pay and level of responsibility. Twenty-five (25%) of this group of one hundred were employed at Goodwill on a sheltered workshop level. Thus, forty-six (46%) were described as successfully rehabilitated and fifty-four (54%) as unsuccessful. Only 3% of the sample had a chance to end up with a really competitive job, and it is by no means certain that any actually had done this. It is doubtful whether the remaining 97% will ever gain competitive employment; they have too many deficits to succeed in becoming members of the regular work force.

Outcome of One Hundred Non-Schizophrenic Clients at Goodwill

This is a group of one hundred clients seen by the author simultaneously with the one hundred schizophrenics. They were diagnosed as: psychiatric problems other than schizophrenia (29%), mental retardation (37%), and physical limitation (22%).

The one hundred cases for this sample were randomly selected. The outcome for this second group was: forty-two (42%) placed in competitive employment at jobs of higher responsibility than the schizophrenics, seventeen (17%) placed in vocational schools, and twelve (12%) placed in sheltered employment at Goodwill. The success rate here is 71% and the failure rate is 29%.

The differences between the two samples in terms of employment and in terms of absolute failures are both significant ($p < .001$).

Discussion and Conclusion

The statistics illustrate the fact that what is very badly needed are terminal sheltered workshops where more widely deviant behaviors and lower production can be tolerated. Such facilities now exist for people suffering from mental retardation and cere-

bral palsy, but are pitifully insufficient for the long term mental hospital patient. Their creation would greatly enrich the life of the boarding house resident described above. It would provide him with a change of scene, give him something to do, and increase his income. If the sheltered workshop were a good one, it might also act as a screening device to find candidates who might benefit from vocational rehabilitation with competitive employment as a goal.

Better continuity of care might be provided if hospital personnel could visit former patients at the sheltered workshop, and discuss current problems as well as checking on whether or not the patients were taking their maintenance dose of antipsychotic medication. How long this supervision should continue is really unknown.

Gerald D. Klee, M.D.

Kurt Gorwitz, Sc.D.

Effects of the Baltimore Riots on Psychiatric Hospital Admissions

Following the assassination of Dr. Martin Luther King, Jr., in April of 1968, widespread civil disorder occurred in Negro communities throughout the United States. Rioting occurred in more than 130 cities. Among major urban areas, Baltimore was one of the most seriously affected, with widespread rioting, looting, and burning, during the four day period from Saturday, April 6 to Tuesday, April 9. This situation led to the mobilization of the National Guard and imposition of a curfew in the city and adjacent areas. Between Saturday and Tuesday, thousands of unauthorized persons found on the streets during curfew hours were apprehended by security forces. A number were subsequently convicted of trespassing or other related charges.

Civil disorders of this magnitude, and the counter measures employed to contain them, have innumerable parameters along social, political, economic and psychological lines. Effects were observed in nearly every area of life within and around the city. The purpose of this study was to examine the effects of this civil emergency upon admis-

sion to psychiatric hospitals. It was anticipated that these would be affected by a variety of factors, including logistics, such as availability of diagnostic facilities and transportation. The curfew, which appeared to be more rigidly enforced in the inner areas than in outlying sections, could also be expected to have some effect. In addition, discharge of emotional reactions in anti-social behavior together with emotional reactions to the general state of alarm might be expected to affect expected rates of admission during the period of crisis.

To our knowledge, no studies of this kind have been reported.

Methodology

Admissions from Baltimore City to state operated psychiatric hospitals are assigned geographically to three facilities. Although data are available from the Maryland Psychiatric Case Register on admissions to privately operated psychiatric hospitals, these were arbitrarily excluded from this study on the assumption that they would be less affected by the disturbances because of their location, the population served (largely from outside Baltimore City), and the small number of patients involved. Periods of two weeks preceding and following the civil disturbance were examined. For comparison, corresponding data for the same time

Dr. Klee is Professor of Psychiatry, Temple University Health Sciences Center, Philadelphia, Pa. 19140. Dr. Gorwitz is Director of Statistics, Maryland Department of Mental Hygiene, Baltimore, Md.

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span in 1967 were also analyzed. In addition to available statistical data, hospital admission notes were studied for all Baltimore City residents entering these three facilities during the four-day crisis period.

Results

The number of Baltimore City admissions during the two-week period before the onset of the disorders and after their conclusion did not differ markedly from comparable figures for 1967. There were distinct differences in admission patterns during the four-day emergency, however, both as compared with the preceding and the following time periods and also with the comparable period of 1967.

Maryland's psychiatric hospitals have experienced a gradual and consistent increase in admissions of approximately ten percent per year. While this pattern continued during the pre and post riot periods, there was a sharp drop in admissions during the four days of crisis. In 1967's comparable Saturday-Tuesday period, there was a total of 65 admissions to these hospitals. Adding the noted ten percent increase brings the number of expected admissions to 71. In 1968, this number dropped to 50. Further variations were found on the basis of race and diagnosis as well as place of residence. While there were 27 Negro admissions for the four-day period in 1967, this decreased to 18 in 1968. The comparable figures for white residents were 38 and 32. Thus, while a drop in admissions was noted for both races, this decline was more marked for Negroes. In 1968, 31 of the 50 admissions were diagnosed as alcoholic as compared with only 26 of the 65 admissions in 1967. Concurrently, a sharp decline was noted in admissions with a psychotic diagnosis (9 in 1968 versus 24 in 1967).

In 1967's comparable Saturday-Tuesday period, two-thirds of the 65 admissions were

from inner city areas where much of the rioting occurred in 1968. This ratio has been fairly consistent in recent years. During the four days of disturbances, however, only half of the 50 admissions were from this part of the city and half were from outlying areas.

State hospital admission notes on these patients were examined in order to obtain further information regarding circumstances leading to hospitalization. Unfortunately, many of these notes were brief and only described the patient's condition, neglecting to indicate the circumstances leading to hospitalization. It was found, nevertheless, that more than ten percent were directly related to the civil disturbances. For example, four patients were stated to have been picked up by the National Guard for violating curfew and were found to be mentally disabled. Another patient was reported to have been bitten by a police dog.

Discussion

It is not very surprising to observe changes in psychiatric admission rates during a widespread civil disturbance which affected nearly every aspect of life within the city. Because many established routes for examination and disposition of patients were restricted, it might have been predicted that admission rates would drop. Conversely, however, it could have been predicted that admission rates would rise since the general unrest might have had a psychological impact leading to acute disturbances in predisposed individuals. The decrease in the number of Negro admissions may be related to the first factor. It may also have been related to the possibility that rioting served as a discharge of tensions which eliminated the need for some individuals to obtain psychiatric care. Most

likely, in the prevailing martial atmosphere, mentally disturbed Negroes were dealt with differently by authorities than under more normal circumstances. That is, only the most severe and obvious psychiatric disorders would be recognized and dealt with as medical problems. In the white community, there was sharp limitation of movement and only in instances of the most extreme behavior disturbance would families be likely to venture forth to seek immediate psychiatric disposition. For both groups, however, it is interesting to note that after the four days of rioting, there was no observed increase in admissions to compensate for the decline which had occurred during this period. Since the total numbers were small, not too much can be made of this fact.

The rise in alcoholic admissions may be partially accounted for by the complete curtailment of liquor supplies from standard

sources during the disturbance, which unquestionably produced withdrawal symptoms in many long term alcoholics. (All bars and liquor stores were closed during most of the riot period. Baltimore newspapers shortly thereafter reported an upsurge in the numbers of alcoholics with delirium tremens admitted to general hospitals.) Other alcoholics and a few disturbed and confused individuals lacked sufficient judgement and failed to remain indoors during the civil disturbance, leading to their apprehension by the police. Under more normal circumstances, the same individuals might well have remained in the community in their disturbed state without encountering any interference.

These findings provide only a bare statistical analysis of an extremely complex set of events. Further studies along statistical, psychological and clinical lines should be rewarding.

Points of View

Eugene Schoenfeld, M.D., M.P.H.

Doing It in the Road: Folkways vs. Mores

A popular song by the Beatles called "Why Don't We Do It In The Road?" * is a satirical look at our attitudes about sex. They sing that no one will be watching, so why not do "it"? The same question could be directed toward many other matters, including drug use and abuse. Now that anthropomorphic God is dead and we no longer fear punishment nor expect rewards from an old man with a beard—we've created our own hells called cities—we are freer than ever before to choose a way of living, a style of life, morals and manners. We can either follow someone else's code of conduct or invent our own. The old guides have disappeared. The new freedom demands responsibility.

I think it's entirely appropriate to question everything. We must understand that manners, morals and laws, however strange and irrelevant to our existence they may seem, usually have their origin in a reasoned decision. The decision may either have

been entirely correct at the time or based totally on misinformation. A course of action, reasonable when formulated, may now be unnecessary.

Many of our moral sanctions come from our Judeo-Christian heritage.

There is an interesting theory, beloved by pot heads, about the origin of the Ten Commandments. It holds that the burning bush which inspired Moses was a variety of *cannabis sativa*. Moses, the story goes, came upon a smouldering specimen of Mt. Sinai Gold, the wind shifted, he inhaled and—flash—the Ten Commandments.

I read through them recently to see how relevant they were today. Most of them can be retained with only slight modification. The Ninth Commandment, for instance, tells us: "Thou shalt not bear false witness against thy neighbor." Who are our neighbors? Does this mean it's all right to bear false witness against strangers? That wind must have shifted a bit here.

Where does all of that leave us? Back to the idea that we can accept, reject or modify a code of behavior or invent our own. We should recognize that evolving man need not and should not live by immutable arbi-

Dr. Schoenfeld, author of *Dear Dr. Hip Pocrates*, is staff physician at the Student Health Service, University of California, Berkeley. Requests for reprints may be addressed to him at P.O. Box 680, Tiburon, California 94920. This article is adapted from a talk given at the Berkeley Little Theater, April 8, 1969.

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MENTAL HYGIENE

trary codes. But neither should codes be arbitrarily abandoned.

What connection does this have with sex and drugs? Simply that man's gift of memory allows him to learn from experience, both individually and collectively. He can retain the accumulated body of knowledge while, if he chooses, modifying the code of behavior which contributed to the gathering of this knowledge.

To put it more concretely, I believe we should strive to separate as best we can facts from moral stances.

Consider the question of drugs. What is a drug?

1. LSD, marijuana, mescaline? Yes.
2. heroin, alcohol, aspirin? Yes.
3. caffeine, tobacco, penicillin? Yes.

What about vitamins? The Food and Drug Administration wants to control them as drugs. Foods contain vitamins

"Drugs" have taken on a bad connotation while "vitamins" represent health and energy. Yet an overdose of Vitamin A can cause loss of appetite, irritability, itching, loss of scalp hair, thickening of the covering of bones, and an enlarged liver. A deficiency of Vitamin A, on the other hand, may cause night blindness and ulceration of the eye's cornea and conjunctiva. Is the body arguing for moderation?

What about mind-altering drugs like alcohol, marijuana and LSD? Are they harmful? Are they helpful? It depends on the circumstances, the individual and whether the drug is used or abused. The port wine I have prescribed for the benefit of little old ladies can be poison for a skid row wino. A Cal student who occasionally eats one or two Alice B. Toklas brownies and settles in a comfortable chair for an afternoon of listening to Indian ragas is unlikely to do harm to himself or others. But no drug is completely safe for everyone.

I have treated several students who used

marijuana for the first time, became very frightened and sought medical attention. One was a nineteen year old freshman who became aware of his strong homosexual feelings, panicked and threatened suicide. Two policemen brought him to the hospital. I asked one of them, a Black man, what had happened.

Restrictions placed on psychedelic drug research are harmful not only because such information might be beneficial to psychiatrists and others but because lack of information may cause users of these drugs to unwittingly do harm.

"Oh, he was smoking pot for the first time," he replied. They left without filing charges, recognizing that the important question here was not a matter of legality but of possible harm to an individual.

An interesting study might be conducted in college dispensaries charting the decline in visits for acute alcohol intoxication during the past few years against visits for untoward marijuana reactions. I am virtually certain the study would show fewer total dispensary visits.

Restrictions placed on psychedelic drug research are harmful not only because such information might be beneficial to psychiatrists and others but because lack of information may cause users of these drugs to unwittingly do harm. Recently, I received the following letter:

"For the nine months of my pregnancy I refrained from taking any drugs, psychedelic or other. Now that my baby has arrived, I would like to resume taking acid and mescaline. But I plan to breast feed for at least 6 months.

Will these drugs reach my baby through my milk and, if so, will they come through strongly enough to affect him? I could express the milk by hand before dropping (ingesting the drugs, ed.) but how long would the drugs remain in my milk supply? Please advise."

This is one of the most commonly asked questions as I open my mail each week. The best advice I can give is that no one knows yet whether LSD, mescaline or marijuana enter breast milk but it's better not to take a chance. The mother is willing to risk her own health but not her baby's, and this concern, it seems to me, is not being shared by those who could authorize a study of this and related questions in laboratory animals.

The general distrust of the "establishment" by large segments of the population extends to members of the healing professions, sometimes with good reason. I received the following letter from a Napa, Calif. housewife:

"I have six children and would like to find a way to present my soulmate with a more shrunken area to play in. Dig? I was told by my physician that I had an "unusually good pelvic floor for having had 6 children" (whatever that means) and I have exercised my muscles but I think I have accomplished all that can be done that way. My husband is sweet and says it doesn't make that much difference but. . . .

Incidentally, I called my doctor to ask if I could, at this late date, have a minor surgical repair as I had my children by natural childbirth and didn't need repair then. The nurse I had to clear it through was grossly offended, wouldn't bother the doctor with it and called me a 'perverted slut'."

I advised this woman to call the nurse's remark to the attention of her physician because any perversion involved here rested with the nurse, not the woman.

The current VD epidemic is another kind of perversion. On the one hand we have changing moral values including more sexual activity at an earlier age. On the other hand we have the shame, guilt and fear which prevent effective dissemination of information and prompt diagnosis and treatment. One method of combating VD is to damn fornication.

Damning fornication remains the most common method used to prevent VD. Perhaps vaccines against gonorrhea and syphilis will someday be available but until that happens the best course to follow is to regard them without shame as diseases.

Why is it we don't do it in the road—even if no one's watching us? One reason is that we may be run down by a truck.

Another reason is similar to the answer I give those who ask whether VD can be caught in a bathroom. It's possible but damned uncomfortable.

Primary Prevention: A Challenge to Mental Health Associations

At the 1967 annual meeting of the National Association for Mental Health Dr. Moody C. Bettis¹ presented a strong argument for redirecting the focus of the Association's program to prevention of mental illness, one of the original emphases at its founding 60 years before. That challenge stressed the importance of primary prevention, which has received little attention from mental health professionals. As the Association considers its future program emphasis, it is therefore appropriate to review briefly the current posture of primary prevention.

For centuries, mental health professionals believed the social problem of mental illness could be solved by treatment of those afflicted with mental disorders. But Ryan² reminds us that, throughout the history of public health, "The fact is that no major human disorder or disease has ever been controlled by treating the diseased individuals." As decades of modern, enlightened treatment methods have not produced any significant inroads into prevalence and

incidence rates, systematic attention to prevention is long overdue.

The term primary prevention has been taken from the field of public health, where secondary prevention is commonly referred to as early case-finding, diagnosis and treatment, and tertiary prevention as treatment of existing disease to restore maximum functioning and prevent disability. Primary prevention is therefore the most basic of the three levels, and the meaning of the term "prevention" when it is used without qualification by laymen and many professionals.

The conceptual frameworks and program ideas for primary prevention suggested by Caplan and Bower^{3,4} are the ones most widely referred to in mental health literature; it would not do them justice to attempt summaries of their concepts in the space available here.⁵ Significantly, in the five and six years since publication of their respective theories, neither work appears to have been criticized on theoretical or practical grounds.

Negative Views

Yet statements continue to be made that mental illness cannot be prevented, at the

Mr. VanAntwerp is consultant to courts, law enforcement agencies, and attorneys with the Jefferson Medical College Community Mental Health Center, Philadelphia, Pa. This article draws on work done at the Graduate Department of Social Work and Social Research of Bryn Mawr College. Requests for reprints may be sent to Mr. VanAntwerp at 231 Valley Road, Merion Station, Pa. 19066.

⁵ See the many references collected in Blomstein, S.: *Prevention in Mental Health: Selected Annotated Bibliography*. *Canada's Mental Health*, 17: Suppl. No. 61 (May-August), 1969.

present stage of psychiatric knowledge. Early in 1907 Henry A. Davidson⁴ traced the history of the mental hygiene movement from treatment of adults, then of adolescents, of children, of infants, and back again to adults. He concluded that mental hygiene programs cannot be justified for the prevention that results, as this cannot be proved, but can nonetheless be justified for the good that is done by treating those who are ill.

This, however, overlooks the fact that primary prevention is accomplished not by treating the ill but by intervening in social systems and with individuals before disorders are manifested. Cawell⁵ has explained the applicability in mental health of a principle of public health, that the theories needed to prevent a disorder or successors are very different from the theories needed to treat existing cases of the same disorder.

Another argument frequently heard is that primary prevention of mental illness should not be attempted until there is proof that it can be accomplished successfully. This colligium is a rationalization to avoid prevention efforts, because it is clear that primary prevention must be attempted before it can be found effective or ineffective. In any event, the lack of "hard" proof of primary prevention's effectiveness should be no more a hindrance than the lack of similar proof of psychotherapy's effectiveness has been to its use in treatment of chronic for most mental disorders, or the absence of proof of mental health education's effectiveness⁶ to wide use of education programs as a mental hygiene method.

Unfortunately, the arguments against making primary prevention a significant part of mental health programming carry over to research. So far as the literature reveals, little or no research is being done to determine the most effective means of pre-

venting mental illness. So long as the factors that work against practice of primary prevention are also blocking research in prevention, there is little likelihood of substantial breakthroughs resulting from the work of pure theoreticians. As an indication of the research potential, Murphy⁷ has outlined a series of controlled research efforts using techniques of experimental psychology as a means of testing prevention programs.

Reasons to Proceed

In spite of difficulties, there are good reasons for attention to primary prevention, and for mental health associations to make prevention a high priority goal in their own programs. While there was a great and valid need for citizen attention to treatment of the mentally ill in past years, today conditions in mental hospitals are much improved due to citizen efforts and increased governmental funding. Thus it is an appropriate time to reexamine priorities.

With the growing number of community mental health centers, the major portion of mental health programming in communities is passing from private clinic and hospital efforts to centers which are either directly or indirectly government controlled. The primary role of the citizen mental health movement may appropriately be shifted from service provider to influencer of policy. Indeed, in most communities the mental health association will be the only informed citizen group with an interest in mental health.

Mental health association resources will also be freed for such broader activities in

The background of many professional NAMH staff members is such that they must themselves be educated before their Boards can be expected to understand prevention.

the spread of community mental health centers. The consultation and education service which is a mandated responsibility of each federally funded center should in time supplant many education functions which previously were performed by men-

torials can be expected to understand prevention. In a recent survey² of mental health professionals, background data was obtained from 25 state and members of mental health associations of state and major metropolitan areas. Only 11 had had

It is clear that primary prevention must be attempted before it can be found effective or ineffective.

tal health associations in the absence of any public agency with that responsibility. Similarly, 24 hour emergency services and new governmental information and referral programs will render unnecessary many citizen programs of these types. In the rearrangement of citizen movement patterns that must result, prevention should be given a high place in local programs and in NAMI guidelines that influence divisions and chapters.

Overcoming of Difficulties

After decades of focusing on treatment and service, it will not be easy for mental health associations to refocus on prevention. Everyone involved in mental health work shares the difficulty of conceptualizing and carrying out new programs of primary prevention, compared with the least difficulties of treatment theories and methods that are well known.

Another difficulty is the personal orientation toward clinical treatment of many mental health professionals. The clinical orientation of many professionals occupying influential positions in associations, Boards and Professional Advisory Councils will inevitably cause opposition or at best indifference toward prevention on the part of association decision makers.

The backgrounds of many professional NAMI staff members is such that they must themselves be educated before their

training in one of the three mental health professions and another 10 in education, public health, sociology or social sciences. Even a psychologist or social worker with a clinical background might have difficulty interpreting the potential of primary prevention to his membership, unless with a mental nurse background or experience in public relations or business administration may need considerable study and education in order to develop these concepts into effective advocates for prevention programming.

NAMI's Role

Nonetheless by a strong and concerted effort NAMI and its affiliates can overcome these difficulties and become powerful spokesmen for the place of primary prevention in community mental health programs. Our social institutions, both governmental and private are creating a new era of responsibility and commitment in the affairs of these communities. The most important future role of the mental health association may well be that of national advocate of programs and policies such as prevention of suicide through all channels.

The role of advocate can be strengthened if mental health associations become widely representative of all segments of their communities, to a greater extent than has been traditional in many areas. A diverse group

with broad middle-class board membership of course has the potential for effective community action. But today one that speaks with voices and viewpoints of the poor, as well, can be an even more effective advocate of its position to the community's agencies and institutions engaged in mental health activities.

The years to come will be a crucial period both for the future of prevention efforts and for the continuing relevance of the citizen mental health movement. If mental illness is to be removed from the list of our nation's social problems, mental health associations must rise to the challenge and lead efforts to accomplish primary prevention.

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The need for differentiation in rehabilitating the mentally retarded

The educational concepts currently employed in dealing with mentally impaired youth are primarily oriented towards vocational training and are based on general educational standards developed by various schools of education. There is neglect of educational aspects derived from consideration of the specific pathologies from which these youth suffer. As a means of differentiation we use mainly the IQ level or some other similar general performance scales.

There is, however, another basis for differentiating pathological behavior which I call the "dynamic aspect." It is the dynamism in behavior that makes an individual active in performance and in adjustment to vocational tasks and to the community in which he is to perform. Looking at three characteristic forms of pathology—cerebral palsy, polio, and epilepsy—shows that young persons suffering from these pathologies display, dynamically, quite different behavior. These differences

in behavior must be taken into consideration if we are to help these individuals to adjust vocationally and even socially. Following are brief psychological characterizations of each of these three forms.

1. **The cerebral-palsied.** Those who have closely observed the cerebral-palsied are familiar with the powerful impulse in most of them to compensate for impairment and deficiency. This compensatory energy output clearly demonstrates a specific physiognomy that demands a kind of specific educational approach that has only to a small degree been utilized in our wider general and vocational remedial work.

2. **The polio-impaired.** Most polio sufferers offer a psychopathologically different picture. Psychologically, polio strikes the individual like a thunderbolt. The impulse source of personal dynamic incentive is lamed, in some sufferers destroyed. Many individuals struck by polio remain thereafter frightened, insecure, fearful, and easily irritated. Helping them to get over their retardedness and achieve more or less acceptable vocational functioning is a slow and tedious task.

3. **The epileptic.** Seen from the point of view of this paper, the epileptic offers, dynamically, a completely different picture

Dr. Harms is in private practice and serves as a consultant to the Narcotic Addiction Control Commission in New York City. He has worked with the mentally retarded in institutions and with the Department of Vocational Rehabilitation. Requests for reprints should be sent to him at 158 East 95th Street, New York, N.Y. 10028.

than does, for example, the polio victim. He starts things and does not finish them, he is hesitant, and he behaves as if constantly expecting something negative to happen. He panics easily and is a chronic pessimist. He quickly abandons something he was enthusiastic about only a short time before. One day he does excellent work, the next day he fails badly. He is the most difficult of the three types to train for vocational and remedial adjustment.

In our remedial efforts we need to differentiate between the various types of the mentally retarded. The compensatory

factor in the cerebral-palsied has received acknowledgment here and there, but what is needed is a basic view of this aspect and the development of a specific educational system for it. This is even more true with regard to remedial teaching and vocational training of polio sufferers and epileptics. For these no specific educational views and techniques have yet been developed. Only if we have such specific educational systems, carefully adjusted to the pathological type, can we hope to do a satisfactory job of adjusting.

*Hello
 When the phone
 Stops
 Ringing,
 And the roses
 Fall,
 And the clock
 Dies,
 The room
 Fills with the blue
 Of yesterday,
 Twilight,
 Sleep,
 And goodbye,
 And
 Hello,
 To tomorrow.*

Annis Wa

Nathan W. Ackerman, M.D.

What happened to the family?

The author examines the breakdown of the family in modern society and proposes steps to halt the disintegration of family life. He believes that if present trends continue, the forces of reintegration will not offset the factors of decay.

Much has happened, much continues to happen to the family. What does it all mean? Is the integrity of the family in jeopardy? Do we have a "sick" family imbedded within a sick society?

Judgments as to the nature and significance of family change are strangely paradoxical. They gravitate to two extreme poles: 1. The family is changing, but no need for alarm, it is merely changing its style to fit the times; 2. The family is failing; it is no longer equipped to do its job for society. Some say that signs of family breakdown are confined to a small fraction of the community, the so-called "hard-core" families, while most families continue "normal and healthy". Others say that the family is spiritually bankrupt; it is a defunct social institution that has out-lived its usefulness. Where lies the truth? What is the present condition of the family? How did it get that way? How should it be? What can we do to make it as we would like it?

Why this "schizophrenic" split in the evaluation of family life today? Concerning

this, I hold a private hunch: The explanation may lie hidden in our respective wishes and dreams about the family of tomorrow. In the torn and troubled world of today, we have difficulty in diagnosing what ails the family. We are unable to read the future. We are immobilized and can not decide what kind of family and society we really want.

The malady of the modern family shows itself in several ways: 1. A form of family anomie, reflected in a lack of consensus on values, a disturbance in identity relations and a pervasive sense of powerlessness; 2. Chronic immaturity, the inability to assume effective responsibility, and an impaired potential for viable family growth; 3. Discontinuity and incongruity in the relations between family and society.

Let us take a closer look. Many of the traditional functions—work, education, religion, care of the sick and aged—have been removed from the family and displaced to the wider community. The family is cut off from tradition. It is failing in its search for horizontal supports in the community. It is pushed and pulled. As the force of family tradition weakens, the influence of the peer culture takes over. The needed

Dr. Ackerman is Director of Professional Program at The Family Institute, 149 East 78th St., New York, N.Y. 10021.

balance between the standards of tradition and those of the oncoming generation is thrown off kilter. The power of the past is reduced. The pressures of the here and now mount. The unity, stability and continuity of the family unit is endangered.

In relations with wider society, people are confused and frightened. Unable to find a safe place in the world, the individual is thrown back on his family group for the restoration of a sense of security, belongingness, dignity and worth. This puts an extra load on the family for togetherness. Is the contemporary family equipped to bear this added pressure? Not very well! Togetherness as a family ideal is propagandized everywhere precisely because there is not enough of it, and as families go today, many of us just can't take it. In place of the real thing, one finds a trumped-up, artificial kind of togetherness. The tension of closeness at home is sometimes unbearable. In the aggravated anxieties of our time we require more and more distance from people, especially from family people. When the family does get together, there are dramatic signs of suffering and distress, quarrels, violence, depression, or the symptoms of Sunday neurosis, headache, nausea, backache, etc. Comes the family dinner at the Christmas season, there is a classic contagion of depression. The special function of socializing the children and stabilizing the adults remains a crucial one. Is the modern family still able to fulfill this function, or is it something like Custer's last stand?

There is the interesting parable by Schopenhauer, which lights up the problem. The parable compares social relations to a situation in which two porcupines found themselves on a bitter, wintery day. Since they were freezing they moved closer together to keep warm, but soon they found they were hurting each other with their

quills. Thereupon, they moved apart—only to find themselves freezing again. Thus the poor porcupines moved back and forth, freezing and hurting, until they finally found the optimum distance at which they could stay warm and yet not hurt each other too much. In our day, the members of the family group have not yet found that optimum distance.

The changes occurring in the family of Western society are pervasive. People marry earlier, they separate and divorce more frequently. There is a decline of the large kinship group and a relative isolation of the nuclear family. Grandparents and other relatives lose significance. There is no pattern of sustained emotional support for the young mother, no built-in mother's helper. The family moves about frequently. It grows no deep roots in the surrounding community. The pull of social forces is toward the outside. Each member tends to go his own way.

In the so-called "normal" family, there is a reduced feeling of kinship, of identity, a conspicuous tendency to emotional alienation, a barrier to warmth and affection. The intimacy and mutuality of family relationships grow thin. The symbols of authority, the standards of cooperation, the division of labor, become confused. The roles of father, mother and child are not clearly delineated. Father and mother do not know what to expect of one another. Neither knows what to expect of the child. Often it is the child who usurps control. The family breaks up into warring factions. The conflict may be organized as a battle of the sexes or a war of the generations. Scapegoating runs rampant. In a selective manner, some functions are preserved while others are sacrificed. The bond of mother-child may be fortified while the intimacy of husband and wife suffers or vice versa. Spontaneity and creative expression may be

subordinated to an excessive need for security, or an overemphasis on discipline. The personal growth of a member may be sacrificed to the striving toward social conformity. If such distortion persists, in the end all family bonds are weakened, and family functions are impaired.

There is the changed position of the woman, her achievement of parity with the man, her sexual emancipation, her newfound right to work. But neither husband nor wife can take the allegiance of the other for granted. A man pursues the suicidal cult of masculinity. It is not enough to be a man; one must prove himself to be a superman. With father away much of the day, the cult of "momism" takes over. The relations of male and female are thrown off balance.

The sexual relation between the parents ceases to be lovemaking; it becomes a proving ground for a drive for mastery, a struggle for competitive dominance. The sex act becomes routine, impersonal, jaded. The expression of tender sentiment diminishes and sexual union dies a slow, withering death. Not infrequently the roles of male and female become blurred and almost indistinguishable, or may be reversed.

The emotional climate within the home becomes pervaded by mistrust, doubt and fear. Parents become unsure, unnatural, stilted. Plagued by their sense of inadequacy, they vie with one another and compete with their own children. Failing to mature, they vacillate between a feeling of child-like helplessness and a false, frantic assertion of omnipotent supremacy. Mostly, the parents do not attain the balanced wisdom of true adulthood.

Often parents function with an image of profit and loss in family relationships. They seem to be afraid to love their children. It is as if in giving love, they lose something they need for themselves. They perceive

the usual demands of children as exorbitant. They project to the children unwanted qualities of their own, especially their fears and hates. They scapegoat their children, who in turn scapegoat them. Through their default as parents their authority dwindles and they soon find themselves governed by their children.

It seems currently fashionable to highlight the failure of communication in family life. Concerning this, I would ask: Were human beings invented to serve communication or is communication intended to serve the needs of human intercourse? The real problem is not the loss of ability to talk, but rather the loss of ability to feel and to care for the other person. So long as people feel, they can also talk. Again and again I hear the complaint: "He just doesn't feel me; he doesn't even know I exist". "Failure of communication" is merely the shadow. The real thing is the insidious destruction of relationships through alienation. Alienation has two meanings, estrangement or detachment and a trend toward depersonalization, toward a state of mind approaching madness. This is the true cancer in human relations today.

In this setting the characters of the children are prone to develop in an uneven, often warped way. Too often, they are virtually raised by a single parent, the mother. They experience distress in their striving to achieve a fit between their image of self and that of their parents. They feel themselves as parts rather than as whole beings. They identify in a fragmented way with the qualities of one or the other parent, but cannot establish a secure link with the parents as a couple because the parents are simply not joined. The children become confused as to what the family stands for and they lose their way. They have difficulty distinguishing real and unreal, appropriate and inappropriate behavior.

Among our adolescents we see anarchy and violence, sexual revolt, withdrawal, a sense of defeat and cynicism, a loss of faith and hope in the future, a disillusionment in the symbols of parental and social authority. In one or another way the youth act out the currents of conflict, the destructive competition and the clash of values that infiltrate the interpersonal climate of the family and community. In every age, the adolescents and adult members of the community must come to terms. Each needs the other, each is responsible for the other, each draws judgment on the other. Adolescent struggle reflects in part a valid protest, a correct criticism of the imbalance, disorder and sickness of existing patterns of family and community. This is the root source of the restlessness and revolt of youth on the streets and on the college campuses.

What shall we say of the sexual revolution and the volcanic violence of our time? The shift in sexual attitudes and behavior, the spasms of violence are part and parcel of the revolution in our whole way of life. The smell of death and destruction pollutes our atmosphere. The feeling of youth is: There may be no tomorrow, so why wait? Everybody is in a hurry. They want it now, not later. In this hectic rush, all stages of development are up-dated and accelerated, boy-girl parties, dances, dating, going steady, experimentation with sex, living together, immature marriage and premature parenthood.

As a possible antidote to immature marriage and premature parenthood, Margaret Mead suggests a new style, "Marriage in Two Steps"—individual marriage and parental marriage. Individual marriage entails a minimum of mutual responsibility; it is easily dissolved. The lasting commitment is reserved for a later parental marriage. At first glance this separation of the

sexual contract from the parental contract is enticing in its simplicity. It combines the radicalism of free choice of young couples and the conservatism of stable, responsible parenthood. Ostensibly, it would support the virtues of freedom, flexibility and adventure in the lives of young people, while safeguarding the continuity of family across the generations. To the young it offers a reassuring balm against the fright of marriage as a trap. But is it natural to divorce sexual union from parenthood? Is there not a hidden danger? The proposed new style, individual marriage seems to offer the spurious lure of having one's cake and eating it, too. Instead of enhancing the intimacy and commitment of male and female, it may paradoxically aggravate the trend toward transient, superficial relationships. Marriage and family are grown-up business, not "kid stuff". Mead's proposal would seem to offer a stop-gap, rather than an effective solution to a basic problem. It is easy to understand the frantic sex-seeking of young people as a protest against the alienation, anxiety and spiritual bankruptcy of adult relationships, but it is not a social program. Mead's suggestion, "Marriage in Two Steps", seems to yield to a symptom, the turbulence, confusion, immaturity, and revolt of youth, rather than to tackle underlying causes.

Thus far I have dwelt one-sidedly on the negative, disintegrating trends of family life. What of the potentials for restitution and healing? Let us first specify a few of these compensatory and healing forces:

1. A shared search for suitable solutions to conflict in family relationships.
2. A strengthening of family unity, integrity and functional competence through an enhancement of the bond of love and loyalty, and with this a consolidation of sound family values.
3. Mobilization of external support for

family unity, stability and growth through community and social service—religious, guidance, psychotherapy, etc.

4. Reintegration of family role relationships through tightening of the family organization; rigidification of authority, sharper division of labor, constriction and compartmentalization of roles.

5. Reintegration of family role relationships through a loosening of the family organization; dilution of the family bond, distancing, alienation, role segregation; thinning of the border between family and community and displacement of family functions from inside to outside.

6. Realignment of family relationships through splitting of the group and scapegoating of a part of the family.

7. Reduction of conflict and danger through avoidance, denial and isolation.

8. Reduction of conflict and danger through compromise, compensation and escape, i.e. sexual escapades, delinquency, alcohol, drugs, etc.

If we add up the evidence, it would appear that the forces of restitution, healing and reintegration lag critically behind the forces of disintegration and decay. The old patterns of family organization are falling apart. There is a delay in the discovery and establishment of appropriate new patterns. On the evidence, one is impelled to the conclusion that the healing trends in family life today are incomplete, pathogenic and bring further complications.

The Victim

**I have hurt you,
Twisted the knife in
Deep
To protect
My own
Open wound.
Forgive me,
While I watch
Your blood flow.
I can only
Save my
Own,
While you lie
Gaping,
Dying
On the field.**

—Annie Wu

Book Reviews

Psychological Aspects of International Conflict

By Ross Stagner, Ph.D.

Belmont, Calif., Brooks/Cole, 1967. 234 pp.; \$4.50

Dr. Stagner, psychology chairman at Wayne State University, provides historical perspective of international conflict, and reflects on the perceptual biases which give rise or continuance to this conflict. Concepts such as "the self fulfilling prophecy", popular delusions fostering international differences, and moving man toward war are carefully dissected.

However, it is when Dr. Stagner explores the dynamics of nationalism, the power elite, and the schizophrenic-like behavior exhibited when separating one's social role from the carrying out of policy decisions that the unique contributions of the behavioral scientist appear.

His work does not stop at this point as many might. Instead, he analyzes why negotiators usually fail, then he proposes methods for ending the arms race, supports a supranational system of control for violence, after which he carefully develops the guideposts which constitute the long road to peace.

ROBERT V. HECKEL, PH.D.
Director of Clinical
Training
University of South
Carolina
Department of Psychology

Executive Stress

By Harry Levinson, Ph.D.

New York, Harper & Row, 1970. 282 pp.; \$6.95.

According to the description on the jacket, Executive Stress is an aid to today's businessman at any level. It presents sound advice to anyone who works or aspires to work in a

managerial role and wishes to function at his best on the job.

The publication offers some interesting information (hard drivers don't become president, instead it is the more relaxed men, who draw on the hard drivers below them), a few helpful definitions (a review of the Menninger Foundation's profile of the mentally healthy individual), and a few *bons mots* (books on how to be happy though alive, sell by the millions).

Generally, it provides a little bit of business administration (participative management), a little bit of social work (involvement of the client in defining his own problem), a little bit of psychiatry (understanding basic drives and needs), and a little bit of psychology (sensitivity training).

Unfortunately though, it's too consistently a little bit of everything. I kept coming to topics anticipating that I was finally getting to something helpful only to have them treated so cursorily that I constantly felt let down. For instance, his chapter on the "Management of Women" is covered in five pages and even those are rather cushioned with generalizations such as "correspondingly greater attention will have to be given to making the work place more congenial to women."

Generally, I found the contents thin. In fairness, the author did forewarn that the book represented only an initial step toward an executive's own mental health. I found myself hoping and expecting, however, that it would be a larger step or at least more than a scattering of little ones.

BRIAN O'CONNELL
New York, N.Y.

Mass Behavior in Battle and Captivity, The Communist Soldier in the Korean War

Edited by William C. Bradbury, Samuel M. Meyers and Albert D. Biderman

Chicago, University of Chicago Press, 1968. 377 pp.; \$11.

This book reports a Human Resources Research Office sponsored study of Communist

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soldiers before and during battle and in captivity, based largely upon interviews with several hundred Chinese and North Korean prisoners plus information gleaned from U.S. military and other sources.

It was in a desperate attempt to account for the unique developments arising among these POW's (in particular, the formation of disciplined factions among them, the widespread rejection of repatriation and the organized resistance to UN authority on the part of these prisoners) that social science research into the motivation of these prisoners was requested. The result is a vivid portrayal of the problems confronting the camp administration—but it is at best a one-sided coverage which fails to tell of the camp inefficiencies and abuses which the well-trained Communist cadres found easy to exploit.

It is as short-sighted, on the one hand, not to see that the behavior of the Korean and Chinese prisoners and the extraordinary successes of the Communists with the American POW's are both part of the same monolithic socio-political structure as it is, on the other hand, to oversimplify and attribute these remarkable phenomena to some newly invented technique of brain washing and the possession of omnipotent and mysterious "Manchurian Candidate" powers of conditioning.

From the vantage of 1970, the present report seems sadly dated and somehow of limited relevance to the complexities of the contemporary world. Perhaps the most significant and lasting contribution of this book, other than its value as a historical document, is the tribute it pays to the late William C. Bradbury, Professor of Sociology in the University of Chicago until his untimely death in 1958.

CYRIL M. FRANKS, PH.D.
Director, Psychology Service
and Research Center
Neuro-Psychiatric Institute
Princeton, N.J.

Marriage and Personal Development

By Rubin and Gertrude Blanck

New York, Columbia University Press,
1968. 191 pp.; \$6

This book, authored by two non-medical psychoanalysts seems to be an attempt to marry

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psychoanalytic psychology to marital counseling. In the opinion of this reviewer, the wedding comes off rather poorly. One of the partners, psychoanalytic theory, thrives; the other, marital counseling, dies on the vine.

The marriage relationship is approached as if composed of two separate individuals suffering from arrests of growth and unready for marriage as a phase of maturity. Within this framework, conflict and alienation are interpreted as a secondary consequence of defects and arrests in individual personality development; marital disorder as a primary relationship problem is not recognized.

There is no consideration within this volume of the more recent contributions to the dynamics of relationships in the area of communication, systems theory, small group dynamics, family psychotherapy, etc. It is late in the day to tell married people in distress that the reason they can't have a full climatic sex life is because they are orally fixated. The point of view of this volume is anachronistic and out-moded.

The Mirages of Marriage

By William J. Lederer and Don D. Jackson

New York, W. W. Norton, 1968. 473 pp.;
\$7.95

This is a bold, brash expedition into the territory of marital disorders.

The authors have a two-fold objective: to debunk antiquated notions as to the nature and cure of marriage problems; and to redefine the husband-wife partnership through the application of contemporary systems theory.

As a debunker of the romantic delusion about marriage, this is a vivid piece of writing. It is not, however, in any sense a "do it yourself" book. It does not enable people to diagnose their own marriage problem nor to heal it by themselves. Between the lines, there is an unmistakable note of cynicism in the perspective towards marriage. The goal of achieving a "quid pro quo" at the marital bargaining table makes the whole thing look like a business deal.

It is noteworthy that three of the myths they examine concerning the marriage relationship minimize the role of love. Perhaps love is not necessary for a satisfactory marriage but it sure helps. To debunk the romantic delusion about marriage is one thing; to strip the relationship of the sentiment of "love", in the mature sense of that term, is something else again.

Married Love in the Middle Years

By James A. Peterson

New York, Association Press, 1968. 157 pp.; \$4.95

Included in this small, readable volume by a past president of the American Association of Marriage Counselors are thoughtful discussions of the middle age crisis, of the identity struggle of marital partners beginning their descent "on the other side of the mountain". The author takes into account both the psychological and physiological changes pertinent to the conflict experience of marital and parental partners in this middle phase. He discusses in a most sensitive manner issues concerned with vigor, health, the shift and nourishment of new interests, the search for meaning and continuity in married couples moving into "the prime of life".

Perhaps in the minds of some this book would appear to be rather more sentimental than scientific, but surely it is possible to blend the two and, in this instance, the author seems to have succeeded. This is a rare and competent approach to the problems of marriage in middle life. One might raise one qualification; perhaps that the philosophy underlying this work applies most cogently to the middle class, particularly the cultivated middle class. It may, in fact, be less relevant to the marital problems of the middle years among the working class.

NATHAN W. ACKERMAN, M.D.
Director of Professional
Program
The Family Institute
New York, N.Y. 10021

Put-Offs and Come-Ons

By A. H. Chapman, M.D.

New York, Putnam, 1968. 256 pp.; \$5.95

Dr. Chapman sees neurotic symptoms as maneuvers or stratagems that either draw people together (come-ons) or wedge them apart (put-offs). Psychiatric treatment is also visualized as a maneuver or game, with both psychiatrist and patient playing. While the book is breezy in style, the psychiatric mechanisms do ring true, and the text is smoothly written. There is some lack of solidity and practicality in its approach to treatment techniques. On the other hand, the book does call attention to many easily overlooked psychologic mechanisms in the development of symptoms and in the therapist-patient relationship.

JOSEPH HOCHSTADT, M.D.
Santa Monica, Calif.

Death and Bereavement

Edited by Austin H. Kutscher

Springfield, Illinois, Charles C Thomas, 1969. 364 pp.; \$8

This collection of essays is an attempt to explore the death experience from the viewpoints of all who come in contact with it—the dying person, family, medical professionals, paramedical helpers, clergymen, funeral directors, etc. Within its 41 articles are topics such as "The Child Faces His Own Death", "The Condolence Call" and "Nutrition During Bereavement".

While it suffers from the usual defects of any collection by various writers, each essay is an intriguing look at an area which could be a book in itself.

THE REV. ORION N. HUTCHINSON, JR.
Consultant
Medicine and Religion Committee
North Carolina State Medical
Society

Helping: Charlotte Towle on Social Work and Social Casework

Edited by Helen Harris Perlman

Chicago, Illinois, University of Chicago Press, 1969. 307 pp., \$11.50 cloth, \$2.95 paper.

This accumulation of twenty articles on social work written by Charlotte Towle ranging over a period of years from 1936 to the early sixties should offer many beginners in the helping professions a fine introduction into the where, why and how of the helping process. The book should also provide to old hands in the business of helping a welcome review of some of the basic and elementary concepts of their profession.

Miss Perlman is to be commended for the great effort she must have put forth to make this book readable and enjoyable. As she promises in her preface, she did edit articles to avoid repetition and she did as promised present articles, though more than thirty years old, which are applicable and usable by today's standards.

Most practiced social workers will sense a strong feeling of nostalgia as they read these several articles by Charlotte Towle. No graduate or undergraduate student worthy of his degree has failed to read her in the process of gaining his education and I suspect that few teachers will fail to instruct their students to become acquainted with this fine collection of writing.

The reader's understanding of each article is enhanced by a short introductory comment by Miss Perlman. These introductory comments along with Miss Perlman's biography will lead the reader to a deeper understanding and appreciation of the humaneness of Charlotte Towle. Once read, this book will leave the reader with a feeling of having personally known the greatness of Charlotte Towle and in

this sense the book surely fulfills its purpose; if its purpose was to leave a tribute to her.

WALTER R. CONNER, A.C.S.W.
Social Worker,
Northwest Psychiatric Clinic
Eau Claire, Wisconsin

Clinical Psychiatry and Religion

Edited by E. Mansell Pattison, M.D.

Boston, Little, Brown and Co., International Psychiatry Clinics, Vol. 6, No. 4, 1969. 327 pp.; \$21.50 per year subscription

This is a study of religious components in mental health and illness as viewed by 17 prominent psychiatrists and only two clergy-psychologists. The 22 essays are directed to clinicians who, it is claimed, should know something about religion when treating a religious patient and who should be able to collaborate with religious personnel in community mental health programs. The essays are divided into four main topics: theoretical treatments; clinical studies of specific types of religious behavior; the mental health of clergymen; and the role of the clergy and church in mental health programs and case examples of psychiatrist-clergy collaboration in psychotherapy. A valuable bibliography of contemporary books in each area is appended.

The book suffers from an unevenness of style and the lack of thematic continuity. Individual essays are good in encouraging collaboration between psychiatrists and clergymen. They should be effective since they are written by psychiatrists for psychiatrists.

RABBI HENRY ENOCH KAGAN, PH.D., D.D.
(deceased)

BOOKS RECEIVED

Because of space and time limitations, we cannot review all books sent to this journal. Their listing in this column constitutes acknowledgment of the receipt of the volumes indicated. As space, time and subject matter permit, we will publish reviews of the more significant books.

ACTION ON THE STREETS; A HANDBOOK FOR INNER CITY YOUTH WORK. By Frank J. Carney, Hans W. Mattick and John D. Callaway. New York, Association Press, 1969. 156 pp.; \$4.95 cloth, \$2.95 paper. Based on experience gained from the Chicago Youth Development Project over a six-year period, this book covers the elementary information needed by street workers.

A CRITICAL DICTIONARY OF PSYCHOANALYSIS. By Charles Rycroft. New York, Basic Books, 1969. 189 pp.; \$4.95. Everything from abreaction to zoophilia. The author, a psychoanalyst, gives background information for words which places them in the framework of Freudian theory.

THE DREAM IN PSYCHOANALYSIS. By Leon L. Altman, M.D. New York, International Universities Press, 1969. 227 pp.; \$7.50. "Many of those recently trained in psychoanalysis do not know what to do with the dream . . ." writes Dr. Altman. His purpose is to explain dream theory and present case histories.

THE DYNAMICS OF PERSONALITY. By Lewis R. Wolberg, M.D. and John P. Kildahl, Ph.D. New York, Grune and Stratton, Inc., 1970. 322 pp.; \$9.75. Well written and interesting to the middle and upper middle class layman, the book tries to give practical advice and suggestions for using the insights of psychotherapy in everyday life.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. 24. Edited by Ruth S. Eisler, Anna Freud, Edward Glover, Phyllis Greenacre, Heinz Hartman, Edith B. Jackson, Marianne Kris, Lawrence S. Kubie, Bertam D. Lewin, Rudolph M. Loewenstein, Seymour L. Lustman, Marian C. Putnam and Rene A. Spitz. New York, International Universities Press, 1969. 531 pp.; \$12. Twenty contributions organized around the subjects of contributions to psychoanalytic theory, aspects of normal and pathological development and clinical contributions and appli-

cations of analysis make up the latest in this prestigious series.

SCHIZOPHRENIA AND THE NEED-FEAR DILEMMA. By Donald L. Burhnam, M.D., Arthur I. Gladstone, Ph.D. and Robert W. Gibson, M.D. New York, International Universities Press, 1969. 474 pp.; \$12. Based on the results of a six-year study of the significance of interpersonal relationships in schizophrenia, this report examines the need-fear dilemma, which consists of an inordinate need for and susceptibility to the influence of others.

SHAW AND THE DOCTORS. By Roger Boxill. New York, Basic Books, 1969. 199 pp.; \$5.95. For light reading about a controversial man whom the author believes to have been ahead of his time in his opinions about doctors and the practice of medicine.

STUDENTS WITHOUT TEACHERS: The Crisis in the University. By Harold Taylor. New York, McGraw-Hill, 1969. 333 pp.; \$7.95. Clearly written analysis of the problems facing our universities, with guidelines on how to meet them.

TALKING ABOUT DEATH. Edited by Earl A. Grollman. Boston, Mass., Beacon Press, 1970. 29 pp.; \$6. The profuse illustrations and simulated scrawl make this look like a regular children's book. It has a study guide in the back for parents to help them explain death to children.

THE THERAPEUTIC PLAY GROUP. By Mortimer Schiffrer. New York, Grune and Stratton, Inc., 1969. 214 pp.; \$8.75. The book covers all aspects of play group therapy, from theory and practice to furnishing a play room.

TRAUMA, GROWTH AND PERSONALITY. By Phyllis Greenacre, M.D. New York, International Universities Press, 1969. 328 pp.; \$7.50. Reprint of the 1952 classic.

Film Reviews

A Nice Kid Like You (39 Minutes, black & white, 16mm, 1969). Conceived and developed by the Committee on the College Student of the Group for the Advancement of Psychiatry. Under the Committee's guidance, the film was produced by Gene Lichtenstein. Production was made possible by a grant from the Maurice Falk Medical Fund. Distributed by University of California Extension Media Center, Berkeley, California 94720. Sale: \$250; rental: \$15.

The camera seems to be ignored in this film as college students talk frankly about drugs, sex, the generation gap and their personal philosophies of life.

Most of the action takes place in "bull sessions" in college dorm rooms or at private parties. Some very personal discussions are held concerning drug use—mostly LSD and marijuana. One young woman confesses that she is bored with pot and prefers to experience life on her own, without the aid of an "external chemical". A young man jokingly recalls the comment of a narcotic agent who "busted" him, "What is a nice kid like you doing in a place like this?". They talk of the hypocrisy of the middle class rat race. One young man wonders if his father would be proud were he to know that his son was making large sums of money each day, increasing his investments and building a large private business—by selling pot.

Although dissatisfaction with today's society seems to be a general feeling among these college students, they nonetheless have some very deep thoughts concerning the part they are to play in the future. One girl comments that she admired a friend who sat around for two years reading James Joyce's *Ulysses*, until she realized that was all he was doing. He was adding nothing to the world by hiding himself in a book. Most of them show contempt for the education they have received, emphasizing its impractical curriculum, apathetic teachers and empty middle-class goals of comfort and wealth. They find college little help in their search for personal identity and honesty.

The young women are next filmed in a heated discussion on sex and the Pill. Some feel liberated by the Pill, but most are quite con-

cerned about the type of commitment it allows them to make and the new light it puts upon their moral standards. As the discussion moves to comments about parents, the viewers realize that the young people want free discussion with their parents, but understand that it is nearly impossible, merely because parents have to be parents. Many of the girls feel quite close to their parents, but that does not necessarily mean they have open communication with them. One girl comments that there is "something quite reassuring in not having a 'hip' mother".

In the final scene, a few of the young men discuss younger students in high school and their use of drugs. One of them reflects back on his high school days, remembering that he "freaked out" after being elected president of his high school and learning where the power "really was at".

The film does not make any value judgments concerning these young people and their ideas. It attempts to show the viewer various sides to many problems troubling young people and adults alike. Although these college students may not be representative of all young people their age, they do seem to reflect the trend of thought among many members of their generation.

After the first showing, adult groups sometimes react negatively to this film, but often the following discussion leads to requests for a second showing. Many topics are covered in the film, and a second showing is often needed by any audience to grasp most of the comments made. The film serves as an excellent "discussion starter" for adult-young groups in community or school settings, often lending itself quite well to a follow-up panel discussion. It can also be used separately with either young people preparing for college or adults working with young people of that age, since it gives an unbiased look at the world of the college young person. (An excellent discussion guide accompanies the film.)

Pam Wilson
Mental Health Materials
Center
New York, N. Y.

LETTERS TO THE EDITOR

MENTAL HYGIENE encourages discussion of articles which appear in it. Letters to the Editor should be typed, double-spaced, preferably 150 to 200 words in length. The writer's name, professional affiliation if any and address should appear at the end.

TO THE EDITOR:

In the article "Community Accountability and Mental Health Services" (54:2) by Sheldon Schiff, there are several points which urgently call for clarification.

The paper refers to "the recent discontinuance of Lincoln Hospital's mental health program." It is true that the Lincoln Mental Health Services were briefly suspended by action of the City at the time of the crisis in March, 1969. However, the services not only were resumed and are continuing, but several recent developments suggest that some of the more significant innovations at Lincoln are becoming consolidated and institutionalized components of the program.

Dr. Schiff makes such statements as, "The Lincoln Hospital operation included no mechanism for community involvement," and . . . "At no time was there any effort to involve a constituency of concerned citizens in the planning and implementation of the hospital's programs." The statements go beyond the excerpt from Dr. Roman's paper which Dr. Schiff cites to support his position. Roman emphasizes that, "we initiated the program without organized and coherent community support and sponsorship." However, Dr. Roman in a section of the same paper not cited by Dr. Schiff states that . . . "Lincoln developed and implemented the first model of community control in the mental health field. This model involved a unique contractual arrangement between the City and Albert Einstein College of Medicine and a model cities community corporation." Dr. Roman's two statements are entirely consistent. The Lincoln program was "initiated" primarily by the Medical School and Municipal "establishment." During the first several years, while the program was primarily hospital based, there was participation by and collaboration with the community, but it certainly was not "coherent" or "organized." Following introduction of the Neighborhood Center Program, the community's role became progressively more prominent, culminating in the contractual agreement for direct funding of the Model Cities Community Corporation as a semi-auton-

omous component of the Mental Health Center. Furthermore, it was this very movement toward community control which not only intensified the conflict between the establishment and the community but also between some Puerto Rican residents of the community and certain of Lincoln's more militant Black community mental health workers, who then moved toward staff control.

Unlike the Lincoln leadership, the Directors of the Woodlawn program entered the Chicago scene from outside the Municipal and University Establishments and many of their initial sanctions were derived from the community. During the past several years, Woodlawn has taken on more of the characteristics of an establishment based mental health center. Perhaps some of Woodlawn's recent crises amidst charges of racism by the community are, at least in part, a consequence of this development.

I do not mean to suggest that either Lincoln or Woodlawn's crises were merely the inevitable consequence of their development. However, there appear to be certain common critical issues which confront a developing mental health program whether it is initiated primarily by the establishment or the community. Some recent efforts such as the mental health center being developed by the Charles R. Drew Postgraduate Medical School in the Watts area of Los Angeles suggest the possibility that a center may be initiated as a real partnership between the establishment and the community.

It is unlikely that even centers initiated under community sanctioned auspices will be free from the problems described in Dr. Schiff's paper. We can, however, make some contribution to their more productive resolution through consistent critical scrutiny of both the achievements and limitations of programs like Lincoln and Woodlawn. In that spirit, I welcome Dr. Schiff's article as a first step in a continuing and essential exchange.

Harris B. Peck, M.D.
Visiting Professor of
Public Health
University of California
Los Angeles, Calif.

TO THE EDITOR:

The article "Community Accountability and Mental Health Services," (54:2) by Sheldon Schiff is described as comparing "two community mental health centers in urban settings" and pointing out "the problems to be faced by white professionals in their relationships with the Black community."

The unknowing are likely to infer that the problems are related to the racial difference. In the program described, the problems are inherent in the nature of the relationship between the professionals and the community they are presumed to serve.

The traditional relationship in which professionals design programs to meet community needs as the professionals perceive them in ways the professional deem appropriate have for practical purposes no chance of success.

Any program to be successful must be responsive to the need of the consumer of the services as the consumer sees them.

This demands new role relationships between professionals and the community which should be defined in the professional community contract.

Both professionals and community representatives have critical contributions to make to program planning and implementation. The community representatives have grasped this, and are attempting to communicate their awareness to the professionals.

The professional's success depends upon the degree to which he can be aware of and understand the message.

The community can identify the problems, assign priorities to them, and specify what they consider an adequate solution.

The professional can assist in quantifying the problem, estimating the resource requirements for solutions, formulating proposed solutions, giving some projection of what might reasonably be expected of various proposed solutions, administering the program finally agreed upon and providing services within the program.

These contributions, I think, define the most effective roles in the development of successful programs. The community plans its program with the guidance of the professionals. Where administrative procedures require that programs be submitted by professionals, the professional develops a proposal with the guidance of the community.

Careful attention should be given to the quality of the processes of community organization in any vital community effort as the authors indicate. It is of critical importance. You can often tell why a program fails if you can identify the people who had no significant involvement in the planning process.

Ralph C. Kennedy, M.D.
Black Research and Service
Program
U. of California, Davis

Publications from the National Association for Mental Health

Policy and position statements on:

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Joint Commission on Mental Health of Children
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The Law and the Mentally Ill
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Marital Counseling
Strikes by Mental Hospital Employees
Suicide Prevention
Violence and the Mentally Ill

(Free on request from NAMH, 10 Columbus Circle,
New York, N.Y. 10019)

New and revised pamphlets:

Clergy: Clergyman's Guide to Recognizing Serious Mental Illness—Single copy free.
\$6.50 per C
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the disadvantaged) and innovative uses of volunteers. Can be used as a resource in developing new mental health manpower programs for universities, junior colleges, hospitals, clinics, community mental health centers, professional organizations and local mental health associations.

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(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

Approaches to the Care of Long-Term Mental Patients—\$2.50 each.

General Hospital Psychiatric Units: A National Survey—\$1.50 each.

Health Insurance for Mental Illness—\$2.50 each.

Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems—(cloth) \$6.00 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

Private Psychiatric Hospitals: A National Survey—\$1.50 each.

The Community Mental Health Center: An Analysis of Existing Models—\$3.00 each. 5 or more copies \$2.50 each.

The Community Mental Health Center: An Interim Appraisal—(cloth) \$6.50 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

The Psychiatric Emergency: A Study of Patterns of Service, 1966—\$2.50 each. 5 or more copies \$2.00 each.

The Treatment of Alcoholism—\$3.00 each.

Legal Services and Community Mental Health Centers, Henry Weihofen, \$2.00 each.

The Staff of the Mental Health Center: A field study—\$6.00 (hardcover), 4-9 copies \$5.25, 10 or more copies \$4.75.

The Mentally Ill Offender: A Survey of Treatment Programs, Patricia K. Scheidemandel and Charles K. Kanno, \$2.00 each.

Reprints from MENTAL HYGIENE
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Changing Concepts: Care and Caregivers; Matarazzo, Albee, Arnhoff, Bettis; Vol. 52, No. 2, 1968. 25¢

Cigar Box to Personality Box—art "therapy" in junior high school; DeLara; Vol. 52, No. 4, 1968. 15¢

The Citizen and Mental Health (includes list below); Vol. 50, No. 4, 1966. 35¢

The Citizen and Research; Kenefick
Citizens in Mental Health—What Are They For?; Ryan

The State Hospital in the "Bold New Approach" to Care of the Mentally Ill; Seale, Pryer, Easterling

The Clinic and the Community; Simmons
A Look into the Future of Psychiatry; Kubie

Developing an Inner City Mental Health Association; Bower and Elam; Vol. 54, No. 2, 1970. 15¢

The Law and the Mentally Ill, and Aspects of Etiology (includes list below); Vol. 53, No. 1, 1969. 50¢

The Dilemma of Involuntary Commitment: Suggestions for a Measurable Alternative; Penn, Sindberg, Roberts

Some Considerations for Future Mental Health Legislation; Penn, Stover, Giebink, Sindberg
Lawyer in a Mental Hospital: The New York Experiment; Meyer

The Double Life of a Psychiatric Hospital; Davidson

Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior; Shah

The Adjustment of Criminally Insane Patients to a Civil Mental Hospital; White, Krumholz, and Fink
Legal Commitment and Hospital Behavior; Rubington

Law, Society and Mental Illness (includes list below); Vol. 54, No. 1, 1970. \$1

Community Mental Health and the Criminal Justice System; Shah

Development of Community Mental Health Programs in the Civil Area

Tilicut Folies revisited: A Long Range Plan for the Mentally Disordered Offender in Massachusetts; McGarry

New York's Mental Hygiene Law—A Preliminary Evaluation; Zitron, Herman and Kumaoka

Who is Competent to Make a Will?; Weisboim and Uadin
A Radical View of Social Welfare and Mental Health; Ginsberg

Manpower and Training; Matarazzo and Cowne; Vol. 54:3, 1970. 25¢

A Mental Health Curriculum for the Lower Grades; Lombardo; Vol. 52, No. 4, 1968. 50¢

Mental Health Manpower (includes list below); Vol. 53, No. 2 1969. 25¢.

Some Additional Perspectives on Mental Health Manpower; The Mental Health Manpower Dilemma; Bettis and Roberts
Approaches to the Mental Health Manpower Problem. A Review of the Literature; Cowne

Politics, Extremism, and Mental Health (includes list below); Vol. 52, No. 4, 1968. 50¢

Challenge for the Mental Health Association; Branch

Conservative Government and the Mental Health Movement: Prescription for Action. A Panel Discussion. Phillips, Midlarsky, Warren
Psychiatric Politics and the Organizational Crisis; Brown

Paranoia and High Office; Kantor, Herron
Racism, the Family, and Society: A Crisis in Values; Eisenberg

The Psychiatric Patient and the State Vocational Rehabilitation Agency: A Nationwide Survey of State Agency Practices; Wolfe, Havens, Jenks; Vol. 47, No. 4, 1963. 15¢

Research in Mental Health: Results Obtained and Plans for the Future; Malamud; Vol. 43, No. 2, 1959. 15¢

From Sitter to Citizen: A Project of Vocational and Social Rehabilitation; Isaacson; Vol. 42, No. 4, 1958. 15¢

Schizophrenia—Breakdown in individuals at high risk for schizophrenia: possible predispositional perinatal factors; Mednick; Vol. 54, No. 1, 25¢.

A preliminary report of a long range study partially financed by the NAMH. The investigators found a distinctive premorbid pattern of behavior in a group of adolescents who suffered psychiatric breakdown. This pattern was found to be closely associated with pregnancy and birth complications which could have produced anoxic states likely to damage certain areas of the brain.

Social Action for Mental Health; Levinson; Vol. 41, No. 3, 1957. 15¢

Teaching for Personal Growth: An Introduction to New Materials; Borton; Vol. 53, No. 4, 1969. 15¢

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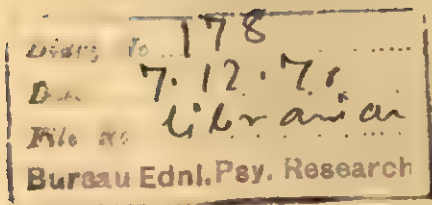
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Wilbert W. Lewis, Ed.D.

Child Advocacy and Ecological Planning

The nationwide child advocacy system recommended by the Joint Commission on Mental Health of Children cannot be implemented within the next several years. We can, however, begin small demonstration programs that will allow us to develop a conceptual framework, the role models and administrative structures that will be necessary to guarantee whatever services are needed to allow all children in a neighborhood to experience normal, healthy development. The specific plan proposed here is based on a model of ecological planning and utilizes three sequential stages: (1) crisis intervention; (2) outreach into the community; and (3) full child advocacy to implement that objective.

The Joint Commission on Mental Health of Children has made as its major recommendation the development of an elaborate nationwide network of child advocacy that will insure to every child whatever services, programs and resources may be required to facilitate his normal development. It is a bold and innovative idea. The structure of its implementation would include agencies at the federal, state, community and neighborhood levels with a broad mandate to see that appropri-

ate health, mental health, educational and welfare services are available as needed in order to avoid or mitigate developmental problems of all kinds. The neighborhood Child Development Council would be the heart of the advocacy system. It would be responsible for monitoring the progress of each child in its jurisdiction, making referrals to service agencies, evaluating the

Dr. Lewis is a Consultant for Mental Health in Education for the National Institute of Mental Health, 5454 Wisconsin Avenue, Chevy Chase, Md. 20015.

The author wishes to express appreciation to the members of the Joint Planning Committee representing the U.S. Office of Education and NIMH who have provided both stimulation and helpful feedback in evolving a plan for school-based child advocacy. This does not, of course, imply any endorsement of the idea by either agency.

effectiveness and availability of services, and introducing new programs as needed with Federal funds. While this aspiration is praiseworthy, such a massive program seems unlikely to be implemented for a number of reasons:

- (1) *The financial resources required, estimates range from 5 to 8 billion dollars a year, do not reflect our current national priorities for children's programs relative to national defense, space, etc.*
- (2) *The policy of the present administration to move responsibility for planning and financing back to states and cities does not allow for the initiation of such a major new program by the federal government within the next several years.*
- (3) *An important criticism of the Joint Commission recommendation is that it does not give sufficient emphasis to programs for children who are already seriously disturbed and for whom insufficient treatment resources are available. Many mental health professionals argue that this situation should be corrected before beginning preventive programs.*
- (4) *We have at present no group of professional persons with the kind of background that would allow them to plan a nationwide child advocacy program; nor indeed have we even any conceptual framework to guide such planning.*
- (5) *Neighborhood Child Development Centers would introduce still another institutional form into communities that would have uncertain jurisdiction over, and compete for funds with, agencies already serving children.*

In spite of these problems the idea of child advocacy is appealing and deserves to be evaluated in careful demonstrations. There is, at present, no group that feels responsible for the welfare of all children in a neighborhood. Parents feel, and exhibit, a wide range of responsibility for their own children. Service agencies either make a judgment about the appropriate-

ness of a child for their services or are required to restrict their attention based on criteria such as age or family income. A child, for example, who is expelled from school and who is not retarded enough for special education, not old enough for vocational rehabilitation, not delinquent enough for the juvenile courts, etc. may simply not be served, educationally or otherwise by existing community agencies. Or what is more deplorable, the community may provide a terribly inappropriate service out of desperation, such as placement of a child needing residential care on a state hospital ward with psychotic adults because there is no other facility available.

How might we best begin to work toward programs of child advocacy, assuming that the beginnings must be modest, making use principally of resources already present in our communities, that we must attend to improving treatment as well as prevention, and that we must provide ourselves an opportunity to learn before moving into community-wide programs affecting the whole range of services for children? While no existing social institution, in its present form, is ideally suited to provide the coordinating and planning functions implied in the idea of child advocacy, the public elementary school may have great potential because of its location, the clear definition of a population of children it serves and by generally positive attitudes of citizens toward public education. Education would need to be redefined as total facilitation of children's development from infancy on. While the school and its advocacy system would not necessarily provide all of the services that children need, ranging from nutrition through treatment for seriously disturbed children, it could provide monitoring and coordination.

Developing Child Advocacy in a School

The following is an outline of the way a program of child advocacy might be developed in a single public elementary school. It assumes that there is already in the community a range of services for children that vary in quality and could be improved by coordination and consultation. It also assumes that some needed services will be missing and that realistic assessment of what is needed can be made only by those who are intimately involved with obtaining services for children in that particular community.

Three stages of development are envisioned in making a gradual transition from presently available services for children to the full range of activities that would be encompassed by a school-based advocacy system concerned with the identification of children's problems, with availability of community resources and with correcting deficiencies in those resources. The three stages are: (1) Crisis intervention on behalf of children identified as deviant by the school, mental health center, juvenile court and public welfare agency. The initial stage emphasizes effective utilization of treatment resources already available in the community; (2) Outreach into the community to families, recreation programs, pre-schools and other formal child-socialization programs with emphasis on early identification, prevention and initiation of new treatment resources identified as missing in stage one; (3) Child advocacy programs, including new services aimed at facilitating the normal development of all children in the community. While the activities of stages one and two will be continued, the emphasis in stage three is on intervention at the level of social systems serving children, both by

modification of existing systems and the addition of new ones as suggested by feedback from earlier stages. No exact timetable is proposed, but for purposes of discussion one might think of about two years for each of the first two stages, moving into child advocacy programs only in the fifth or sixth year.

The organization of such a program is probably beyond the current resources of most public schools. It may be necessary to develop a consortium of different types of social institutions; a public school, parents and citizen groups, a university with training and research resources, a mental health center, etc., depending on the particular array of resources in a community. Membership in the consortium would imply a commitment of resources and personnel to the development of child advocacy appropriate for a particular community, and membership might change from time to time as organizational goals changed.

A Conceptual Framework

A special problem in articulating the efforts of workers from the several professional disciplines concerned with children is that of developing a common frame of reference. The language of mental health is concerned with deviant behavior and does not serve well in education. The language of education is concerned with typical development of perceptual and cognitive skills and does not serve well in social welfare, and so on. We need a broader conceptual framework to maximize the effectiveness of unique professional contributions and minimize confusion among collaborators who do not share a common background of training and experience.

Education would need to be redefined as total facilitation of children's development from infancy on.

A number of mental health and education programs have recently borrowed from field biology the concept of "ecosystem" as a way of conceptualizing about service programs for children. While the biologist is concerned about hydrological cycles, mineral cycles and energy transmission in an ecosystem, the social scientist is concerned with communication of attitudes, expectations, and evaluations among the members of the social systems to which an individual belongs. The idea has been especially helpful in thinking through programs to provide service for emotionally disturbed children by suggesting more variable treatment strategies than are ordinarily used and may be expanded to carry the larger burden of a conceptual framework for child advocacy.

Typically, a child who is called emotionally disturbed has a rather long history of behaviors that depart in important ways from expectations held for him by the important adults in his life who feel responsible for his socialization. Typically, too, he has been examined by a pediatrician, a school psychologist, or the staff of a mental health center or social work agency and they have confirmed the judgment that his behavior is significantly deviant, i.e., he is "emotionally disturbed". It is at this point that one may choose to make an ecological analysis of the problem that will often have implications for more than one child-serving agency.

We begin with the ecosystem to which a child belongs, which means the usual behavior settings and significant people with whom he interacts on a regular basis. For most children this includes home, school, informal peer groups and sometimes more organized group activities such as a boys'

club or a community recreation center. As an abstraction, the ecosystem is difficult to define but for an individual child the definition is made simply by inquiring where and with whom he spends his time. In his natural behavior settings, parents, teachers, peers and others make judgments about how well he is meeting the expectations held for his behavior. To the extent that there are clear and continuing discrepancies in highly valued areas of behavior, there is "discordance" in the ecosystem. Discordance is usually expressed as too much or too little of some expected behavior: "He has an explosive temper, fights at the drop of a hat" (from a parent); "He's so restless, can't settle down to work on an assignment" (from a teacher); or "He picks on the little kids all the time" (from a peer). An ecological analysis considers each source of discordance as a possible target for intervention, based on the general strategy of increasing the effectiveness of the whole ecosystem by solving a number of small problems, each of which alone might be considered of little consequence. Discordance may be reduced in two ways. First, of course, the child's competence in highly valued areas of behavior may be increased so that he meets more of the expectations held for him. Second, the expectations held for him by important members of his ecosystem and opportunities for him to function effectively there may be modified by working directly in those behavior settings where problems usually occur to achieve a better match between the requirements of behavior setting and child behavior.

The details of a program for a child based on such an analysis will be diverse and may call upon skills from a variety of

professional and non-professional backgrounds: training in perceptual-motor skills for a reading disability; supportive counseling for a mother with unrealistic academic expectations; a "big brother" relationship with an older student; instruction for parents in behavior management; consultation with a teacher in using specialized curriculum materials; help for a father in obtaining employment, etc., depending on the type of discordance identified and its location in a child's ecosystem. The same framework might be employed in the initial stage of developing child advocacy since it not only allows a variety of professional skills to be employed but also, since the goals identified are usually quite specific, allows evaluation of the success of the separate components of each attempt at intervention.

Stage I: Crisis Intervention

It is proposed that initiation of a child advocacy process begin with children who have already been identified as deviant by the four major community-wide systems with responsibility for children's socialization, including re-socialization for children identified as socially maladjusted, emotionally disturbed, underachievers, delinquent, etc. The systems are education, mental health, juvenile corrections and social welfare. Each has its own way of defining and responding to deviance in children but all are concerned with those who are not "making it" by failing to meet important expectations regarding competence and appropriateness of behavior.

More specifically, the objectives of the crisis intervention stage are: (1) to identify children who are already in trouble; (2) to coordinate and follow up on existing services that are, or might be, provided to

such children; (3) to provide additional services that are needed but not currently available on a limited and temporary basis; (4) to evaluate the effectiveness of current services in order to plan for change in the delivery systems; and (5) to establish a child advocacy board. Briefly, the rationale for the initial stage is to increase the flow of information among the four systems involved in order to make maximum use of whatever resources are already there for children seen as needing help. There would be no new resources introduced in stage one except personnel to provide liaison between the agencies concerned and the families and children being served.

A serious problem exists in articulating the current patterns of service for children; there is much overlapping, time wasted in getting referrals to appropriate agencies, lack of information about available services, and children can be better served simply by making better use of programs already open to them. In the process of testing this hypothesis it is reasonable to suppose that real gaps in the array of services for children in a particular community will be revealed, such as short-term residential facilities or diagnostic resources for school learning problems, and that these shortcomings will become targets for implementation in stages two and three.

For professional staff in the crisis intervention stage the child development consultant (CDC) model seems most appropriate. This is a new role being developed

A child, for example, who is expelled from school and who is not retarded enough for special education, not old enough for vocational rehabilitation, not delinquent enough for the juvenile courts, etc. may simply not be served. . . .

in five experimental training programs supported by NIMH to train educators with a behavior science orientation to work with teachers and parents in identification and prevention of behavior and learning problems, consultation on behavior management and educational programming, and coordination of various treatment resources in the community. The CDC usually has a background of experience and training in elementary education with additional graduate training in psychology and special education. The CDC training is not all-encompassing and the effective implementation of the role requires carefully planned consultation with specialists from a variety of disciplines concerned with children. Such persons are now available, although not in large numbers, and could be recruited almost immediately as staff for the crisis intervention stage to initiate a child advocacy demonstration. It is anticipated that the number of CDCs assigned to a school will vary as a function of the size of the school and the characteristics of children served by it. As a maximum-minimum estimate, it is possible that a black, inner-city school with a high density of problems and scarcity of services might require a ratio of one CDC to every 100 students enrolled. That is an educated guess based on an incidence level of 15 to 20% and the supposition that each CDC may have to provide substantial direct service in the absence of adequate treatment facilities. In a suburban school with a much lower incidence of problems and a greater number of treatment resources a ratio of one CDC to 500 school children might be adequate.

While the CDC staff may be physically located in the school, they should be administratively responsible to the consortium, including agencies such as a university department of special education, a

Current efforts to evaluate action programs are clumsy and imprecise, usually offering uncertain assessment of experimental programs after they have run their course.

university division of child psychiatry, the city public school system, the mental health center, the county juvenile court, the county welfare department and parents and citizen groups, with a representative of each participating unit as a policy making child advocacy board. The CDC staff will be responsible to the child advocacy board for the coordinating and service functions and for calling attention to deficiencies in current service arrangements. During this stage the board will be primarily in an evaluative stance with regard to the adequacy of services for children rather than moving immediately to change or augment systems. It is to be expected, though, that individual members of the board may return to colleagues in their agency with suggestions that result in modification of service delivery even during the initial stage.

Training and research will be a major continuing concern of the child advocacy board. Even though trained CDCs are available, it is likely that experience will suggest different emphases in the training of new CDCs or the recruitment of different kinds of persons into the role.

Evaluation, in part, will be informal, based on CDC staff reports of problems encountered in working with individual children. Evaluation will also require the development of formal research procedures to document the impact, or lack of it, on children's lives of efforts to provide experiences that reduce deviance and enhance growth. Current efforts to evaluate action programs are clumsy and imprecise, usually offering uncertain assessment of experi-

mental programs after they have run their course. New techniques will need to be developed to indicate not only what a program has done but what it is now doing, to provide constructive feedback for greater effectiveness while it is still under way.

Perhaps the most demanding task for the CDC staff and the child advocacy board during the crisis intervention stage is to plan for stage two: reaching out into the community to develop early identification and prevention programs. Reasoned judgments must be made regarding types of children and types of behavior settings that are related to high risk of deviant behavior in the particular community served. We have, and should use, general leads from prior research about both personal and environmental factors that contribute to deviance but the focus of stage one is on problematic relationships in one specific community and the pattern of organized programs required to solve those particular problems.

Stage II: Outreach into the Community

Stage one is concerned with effective mobilization of treatment resources for children already identified as deviant by the four principal child-socializing institutions in the community. Stage two maintains that concern but broadens its focus to include other institutional forms that address themselves more to normal child development to begin the identification of high-risk children, including pre-schoolers, or high-risk behavior settings prior to the onset of serious deviance, and to begin preventive programs designed to reduce deviance and enhance normal development. The systems to be included in stage two

can be less clearly specified than in stage one. Certainly families must be a central component in any effective effort to reduce the incidence of deviant behavior in children. The designation of other potent components must await assessment of the social dynamics of a particular neighborhood, but one would expect to find included church groups, pre-schools, day care centers, recreation programs, organized athletic programs, boys' clubs, etc., and less formal, but regular, behavior settings such as street gangs or neighborhood play groups. The potential population for preventive programs in the outreach stage is all the children residing in the area served by the elementary school, whether they are attending the school or not.

The specific objectives of the outreach stage, in addition to continuing the crisis intervention programs, are: (1) to develop systematic "early warning" techniques for children who are not yet exhibiting serious deviance but who seem likely to do so based on the history of similar children or children in similar circumstances; (2) to initiate growth-producing programs for children so identified, such as special pre-school experiences or training for their parents; (3) to initiate treatment programs identified as missing in stage one; and (4) to continue to monitor and evaluate effectiveness of the various service components. Generally, the outreach stage is still focused on individual children, although in moving into preventive programming one would anticipate modest changes in, and additions to, the system of services to children such as tutoring programs in the school, weekend recreation programs, etc. Perhaps the most radical innovation in stage two is the aspiration of a single organization to make, and maintain, sufficient contact with all children within a designated area to be able to make a judgment that a particular preventive

program is needed and to act on that judgment.

The staff needed to implement the objectives of the outreach stage are clearly of a different magnitude than for crisis intervention, where coordination and evaluation of existing services is all that is required. At least two new kinds of workers will need to be added. For convenience, one will be called a "home visitor", the other an "educational technician". The role of home visitor is critical in developing techniques for early identification, monitoring the progress of children's development, on-the-spot consultation to parents

Without anticipating specific issues, it is safe to assume that vested interests and unconscious biases exist in all organizational arrangements serving children and will make change difficult.

and other concerned adults in the community and feedback to the child advocacy board regarding effects of preventive efforts. He will work under the supervision of the CDC and, like the CDC, will have available consultation from specialists in mental health, education, social welfare, and corrections. The case load and responsibilities for home visitors will vary with the population served, and the resources already available, such as public health nurses or day care centers, but a necessary condition for their effective functioning is that each home visitor have a clearly designated group of families for whom he feels responsible and acts as advocate in securing services, both remedial and preventive.

While the home visitor is a generalist, concerned with the welfare of a number of families, the educational technician is a specialist in the application of a particular method of intervention that might be use-

ful at times for any of the children served by the advocacy system. "Educational" does not necessarily imply that he works only in the school although it would be convenient for the educational technician to have an area in the school set aside as a resource room in which much of his work with individual children might be done. The particular roles and training required for the educational specialists must await assessment of problems, both of individual children and of behavior settings, during stage one, but it is reasonable to suppose that perceptual training, remedial reading, remedial arithmetic, behavior management, functional analysis of social behavior, group dynamics, and parent education would be among the skills that should be represented in a group of educational technicians. Like the home visitors, the educational technicians will be supervised by CDC staff with consultation from a variety of specialists.

The CDC is an educator with a behavior science orientation. The home visitor and educational technician need not be so extensively, or expensively, trained. The principal requirement of the home visitor is that he be able to establish and maintain rapport with the families assigned him. This may be as much a matter of personal qualities, including socioeconomic background and race, as training, which suggests that home visitors should be recruited from the neighborhood in which they will serve. Initial training might be fairly brief and continued through supervision by the CDC. The educational technician needs to be knowledgeable in depth in a single, or a few, techniques of intervention. An intensive workshop experience might be sufficient in developing the level of skill required in an otherwise untrained person, or the initial assignments might be given to undergraduate students in education or psychology, for practicum credit, in order

to assess the demands of the educational technician roles. With both the home visitor and the educational technician roles, thoughtful consideration needs to be given to the possibility of developing the "career ladder" progression of an income-producing job that is related to a degree or certificate-producing educational program for persons who might not otherwise move through academic requirements into technical or professional positions.

Research during the outreach stage will continue to focus on effectiveness of programs but will be expanded to include some longitudinal studies of systems rather than individual children. Indicators such as number of school failures and exclusions, commitments to juvenile court, etc., will provide systematic feedback to the child advocacy board to help in planning stage three.

Stage III: The Child Advocacy System

The ultimate form of the child advocacy system cannot be described in detail since its specific components will emerge from evaluation and planning during the two earlier stages. It does seem likely that to the emphasis on treatment and prevention of behavior and learning problems will be added a concern with the structure of systems that serve children. The crisis inter-

vention stage is designed to help children who need treatment get whatever is available. The outreach stage is designed to increase the effectiveness of existing services and begin preventive programs with target groups such as parents or pre-schoolers. These two stages are person oriented, directed toward individuals or groups of children who have, or are likely to develop, problems. Stage three will examine the social systems serving children and ask, "How can these systems be modified, restructured or augmented in order to reduce the need for treatment and prevention programs?" At this time we may anticipate three general objectives for fully-developed child advocacy: (1) to identify characteristics of child-serving systems that contribute to deviant behavior; (2) to initiate change in systems so identified; and (3) to evaluate the effects of that change on children's behavior. The task will be a complex one and assumes distinctly political overtones as one moves into the arena of institutional change. Without anticipating specific issues, it is safe to assume that vested interests and unconscious biases exist in all organizational arrangements serving children and will make change difficult. The gradual movement from existing programs to child advocacy will be a test of the hypothesis that given sufficient information and concern we can make our institutional forms responsive to children's needs.

Ethical Considerations in the "Involuntary Commitment" of Children and in Psychological Testing as a Part of Legal Procedures

Many of the precepts that guide mental health professionals in working with children are questioned. The ethical problems that would bother one when working with adults are examined as they relate to children. The author urges all those whose decisions can influence the course of the child's life to be aware of their responsibilities.

Explicit ethical standards usually evolve within a profession from the questioning of comfortable assumptions. This paper will consider some of the assumptions made in committing a child for inpatient care, a decision that requires explicit ethical safeguards and the clear delineation of ethical procedures because most—but not all—children are "involuntary commitments." Child commitments rarely meet the rule-of-thumb legal standard for involuntary commitment of adults, namely that the patient present a clear hazard to himself or to the community.

The legal profession has already defined some standards—work which is contained in the majority opinion prepared by Justice Fortas in the Gault decision, a review of a court case which could have resulted in the institutionalization of a fourteen-year-old

boy for six years for making an obscene phone call. Some of the parallels between juvenile justice and decisions for therapeutic hospitalization are striking. Fortas describes the concepts underlying the relatively recent establishment of the juvenile court system: "The idea of 'crime' and 'punishment' was to be abandoned. The child was to be 'treated' and 'rehabilitated' and the procedures from apprehension through institutionalization were to be 'clinical' rather than punitive." The state was proceeding as "*parens patriae*"—a phrase which Fortas notes was "a great help to those who sought to rationalize the exclusion of juveniles from the constitutional scheme." The early conception of the juvenile court proceeding was one in which "a fatherly judge touched the heart and conscience of the erring youth by talking over his problems . . ." Fortas acknowledges the benevolent motives of most juvenile judges and grants their good will and compassion,

Dr. Tooley is a Staff Psychologist with the Children's Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor, Michigan 48104.

but concludes that the unbridled discretion lodged in juvenile courts is a poor substitute for due process safeguards. (When one is reminded that the heaviest sentence possible for an adult who makes an obscene phone call is two months in jail, the Gault boy seems indeed to have been treated to an excess of "benevolence".)

Fortas takes issue with the rationale that friendly and informal courtroom procedures provide a natural beginning to rehabilitative therapeutic process. He cites evidence that "the child feels enticed and deceived when friendly informal procedures lead to a disposition he regards as punitive and that far from being open to therapeutic change, he feels instead a despairing helplessness in the face of unchallengeable authority . . ." The opinion continues: "The boy is committed to an institution where he may be restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is committed is called an Industrial School. His world becomes 'a bulding with white-washed walls, regimented routine and institutional hours . . .' Instead of mother and father, sisters and brothers, friends and classmates, his world is peopled by guards, custodians, state employees, and delinquents confined with him for anything from waywardness to rape and homicide."

When we turn from Fortas's exposition of his profession's "comfortable assumptions" about rehabilitation to a consideration of our own profession's toward hospitalization, many parallels are apparent: benevolent motives, undeniable compassion for parent and child, a fairly detailed investigation of home conditions and a serene sense that institutionalization will implement therapeutic change. The purpose in considering the existence of attitude bias and blindspots about negative aspects of

hospitalization is to open the possibility that hospital admission committees might need some "due process" safeguards of their own in child commitment procedures. Like juvenile authorities, when we consider commitment of a child we are usually acting against his wishes but "for his own good". Parents are likely to vary greatly in their readiness to consider hospitalization—from great willingness resulting from weary exasperation or exhaustion to extreme reluctance with only a minimal willingness to accept the evaluation of the "experts".

Strangely enough, it is too often only the child who keeps in mind the fact that he will be living in a large institution and be cared for by strangers; that he will be removed from parents, brothers, sisters, pets and the rest of his own personal familiar life space. Since in many cases the professionals who make such decisions work daily in such institutions and become familiar with them and their therapeutic intent and effect, they may forget their frightening and relatively impersonal aspects. In short, professionals making decisions to hospitalize

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are highly likely to hold comfortable assumptions about the benevolent aspects of their own clinical settings.

It should be remembered that all of us who work in therapeutic relationships with children are likely to share another comfortable prejudice—unconsciously and consciously, i.e., that we can be much better parents to a disturbed child than his own

parents could be. This is, of course, the common rescue fantasy which is likely to comprise a considerable segment of the career motivation of all who work with children no matter what the discipline. We ought to be alert to the possibility that it

pitalizing their child needs a representative of its own, someone who can systematically and knowledgeably review the case and explore treatment alternatives—as the legal profession now provides counsel for the family, and in some cases for the child

"... unbridled discretion lodged in juvenile courts is a poor substitute for due process safeguards."

might lead to a tendency to underestimate the traumatic impact of separation from home; or the hazard it presents to a child whose object relatedness may already be weak and diffuse.

Professionals making a decision to hospitalize are often acting on the recommendation of a staff member who has conducted a diagnostic evaluation. He has already made his assessments about the need for removal from a pathogenic home. The tendency to rubberstamp his assessment is strongly reinforced by the prejudicial attitudes discussed above. Too often the only points still open to consideration are considerations about "bed space", training needs or the characteristics of the group already residing in the ward or the cottages. The question about the rightness of this disposition for this child at this time may be too easily obscured or delegated to the intake worker.

Perhaps ethically we ought to force ourselves in such circumstances to make provision in our procedures both to take precautions against our prejudices and to consider the preferences of the child and his parents, not only their needs. We too often set ourselves to "handle" parental resistance to the recommendation to hospitalize and must avoid a tendency to resort to techniques which verge on psychological blackmail in our efforts to do this. The family confronted with a recommendation for hos-

against his parents, instead of relying on the benevolence of the juvenile officer. As with court procedures, such an alternative is usually available to wealthy families and frequently utilized by them. It is middle and lower class families who are dependent on institutional opinion alone.

To return to the Gault decision, Fortas notes that the court official representing the child's interests was also the probation officer and superintendent of the detention home, and he concludes that he cannot act as counsel for the child. "His role in the adjudicatory procedure, by statute and in fact is as arresting officer and witness against the child. Nor can the judge represent the child." He needs, Fortas concludes, counsel of his own. Is it forcing the comparison to suggest that psychiatric personnel requesting inpatient hospitalization for a given child might be influenced in their decision by their other roles and functions in the hospital? Furthermore might they not be impeded in their future therapeutic effectiveness with the child by their role in the commitment procedures?

If the juvenile needs the assistance of counsel "to cope with problems of law, to make skilled inquiry into the facts, to ascertain whether he has a defense and to prepare and submit it," perhaps the prospective inpatient child and his parents need an expert to consider and perhaps to defend the alternatives they might prefer. Those

of us who do our clinical work in residential settings would have difficulty in extricating ourselves emotionally and intellectually from our convictions about residential treatment in order to provide an objective consideration of alternative treatment plans. Community mental health centers, on the other hand, seem ideally qualified to serve this function. Their inclination to keep the child in his home if at all possible would provide a "counter-prejudice" to any tendency to consider hospitalization too casually. Residential treatment centers are few and far between and tend to draw referrals from a large geographic area. Community mental health centers, on the other hand, have much more complete knowledge of the community resources that might be mobilized for a given problem. They are, in summary, natural "defense counsels" who could knowledgeably review and present acceptable, or preferable, alternatives to hospitalization and do much to make up for the present lack of procedural safeguards in child commitment procedures.

The need for due process safeguards is also evident in the current trend toward the use of psychological testing to make life decisions in court cases involving children. A commonly occurring situation is one in

This seems a shocking invasion of privacy and one that, again, is usually justified as being in the child's best interests.

which a lower-class family is charged with child neglect. The case comes to court; the children are made wards of the court and a psychiatric opinion is sought about the degree of psychological damage done so that a proper disposition—foster home, psychiatric setting—can be made. Into the hospital or clinic comes the "ward of the court", usually accompanied by his

"worker" whom he met for the first time a few weeks before under distressing circumstances. He has some sense that his mother, or his parents, are in trouble with the police. He is living in a Child Shelter and has probably been hauled from one forbidding building for a hearing to another for whatever purpose. Now he has been taken, to a hospital perhaps, to confront still another strange adult. Most such children clearly and openly express preference for being "neglected" at home to their current situation.

The child cannot plead the Fifth Amendment and what he unwittingly reveals about himself will be used when the court is trying to decide what to do with him. This seems a shocking invasion of privacy and one that, again, is usually justified as being in the child's best interests. The terribly important question is: "How can we be so sure?" There is nothing in our own experience or in our tools that would qualify us to judge the quality of his home or the pathology of its effect on him. Most psychologists have a limited experience with interpretation of the test performance of working class children—testing is an expensive, lengthy procedure. Since the examiner is likely to be a product of the middle class, he cannot draw on a pool of common experience to implement empathic understanding. If the psychologist has a bias toward middle-class mores, his tests also have a very important bias; they are much more efficient in revealing pathology than they are in revealing compensatory or adaptive reactions to pathology—they reveal the viruses but not the immunological response.*

*It can be argued that all test biases are really psychologist bias—our instruments have been developed according to our own needs and preferences which has resulted in a heavy preponderance of syndrome research to the neglect of normative research.

The psychodiagnostician, then, examines his limited evidence with his limited experience and finds from the testing that the child feels very deprived, feels that he is unprotected and much on his own in a hostile world, and, further, that the child has a reservoir of anti-social, anti-familial hostility and aggression. The psychodiagnostician may well prognosticate a sociopathic character adjustment if the child is not removed from the home—a recommendation received with varying degrees of seriousness by judges who are more aware than we psychologists tend to be of the biases of our instruments. It just could be that all lower class children would be seen in testing as feeling very deprived, unprotected and much on their own in a hostile world.¹ The limitations of the tests and the examiner are not so much a problem when the tests are used only to investigate problem areas, typical defensive strategies and to help focus treatment plans. However, psychological testing should never be used in isolation to determine if psychotherapy or hospitalization is indicated for a given case. The bias of the tests can be corrected by the psychologists' understanding of their (and his) limitations and if they are used in conjunction with many other

psychologist has a clear choice. He can make himself a specialist in testing lower-class children so that he can build a frame of reference, a set of internal norms for judging the degree of aberrance of his child subject's test performance. (This is mainly a problem with poor children. Neglect and abuse in more prosperous families comes more rarely and indirectly to the court's attention. Middle and upper middle class delinquents are more often assigned probationary status and are able to secure psychiatric help on a private basis.) This would allow him to correct for his own middle-class bias and for the test's bias toward revealing pathology. In addition to this, he can refuse to allow himself to testify in disposition hearings as an "expert tester" only. His opinion should be allowed to include interpretation of the test results in conjunction with the interrelation of test material with the current crisis in the child's life and the defensive-expressive style typical of his socio-cultural background. For example, if a child is seen in testing as very frightened, severely depressed, withdrawn and nearly mute, this should not be presented as data about the parent-child relationship without also considering the fact that he has spent two weeks in a child shel-

Younger or less canny and experienced children reveal more than they would wish to.

kinds of information about a child. However, the court rarely uses a psychologist as an interpreter of a wide variety of data—he is the "expert tester", even though his expertise in this field in most cases is based solely on his experience with a pathological population; that is, in clinics and hospitals where his test subjects are already defined as patients by themselves, their families and by other staff members. It seems that the

ter and hasn't seen family, friends or anything reassuringly familiar for that period of time. In evaluating the uncommunicativeness, the psychologist might school himself in some of the sociologists' findings about poor families—that the response of any child or adult from his socio-cultural milieu includes retreat to frightened silence in any contact with "the law."

If the psychologist has not filled the defi-

cit in his background by extensive study of typical projective test performance of working-class or minority groups, he should confine his function to post-hearing testing. When the decision has been made to place a child in a foster home or a psychiatric setting, he can ethically use his tests in the traditional way—to delineate problem areas and suggest effective means for focusing treatment approaches on them. It is commonly suggested that psychological testing provides important information in making disposition decisions. I am suggesting that until we can be sure it is accurate information, free of socio-cultural bias and test bias, it is better withheld.

The psychodiagnostician should consider carefully his frequently phrased reassurance to his child-subject—"We are going to do some tests that will help us to make the best plan for you." Your "best plan" may be a very long psychological distance from his "best plan." We have all no doubt had experience with the child who senses just exactly that. If he is older and has had a longer association with public agencies, he can have a shrewd sense of what we are about. His TAT stories and other less ambiguous projective test responses indicate that his family never does anything but pray and go on picnics. Younger or less canny and experienced children reveal more than

they would wish to. Perhaps all such children ought to be warned about the uses to be made of testing in court. However, warning ought to in no degree diminish the psychologist's ethical responsibility when he uses his tests to see what the child would not willingly show him, to report what would be confidential material if it were willingly and consciously reported by an adult in treatment, to an end which the child would resist strongly if he didn't have an accurate perception of his weakness and helplessness in this situation.

The mental health professions are becoming more and more responsive to suggestions that they define their social responsibilities more broadly. It is important, however, that we do not develop social conscience at the expense of scientific or professional conscience—that we keep clearly in view the limitations of our methods, our training and our life experiences and limit accordingly both our claims to expertise and the responsibilities we undertake.

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David Elkind, Ph.D.

Exploitation and the Generational Conflict

This paper elaborates the thesis that exploitation (breaking of implicit contracts) by parents and adults is often the issue on which the conflict between young people and adults is centered. The first section of the paper presents a general scheme of development of parent-child relations in terms of a series of implicit contracts and explicit agreements and bargains. The next section describes work with middle class delinquents which suggests that developmental exploitation (breaches of the contract by demands for age inappropriate behaviors) and egocentric exploitation (breaches of the contract by demands for excessive amounts of age appropriate behavior or uncompensated behaviors) are related to two phenomenologically different forms of delinquent behavior. In the third section of the paper it is suggested that some forms of exploitation of youth are institutionalized and that changes in the nature of institutionalized exploitation can help to explain, in part at least, the character of today's youth revolt.

The generational conflict between parents and their adolescent offspring is a big problem and one which can be studied from the standpoint of many different disciplines including anthropology, sociology, psychiatry and social psychology. In the present paper, however, I propose to deal with the generational conflict from the perspective of developmental psychology, that is to say, from the position which sees parent-child interaction as evolving in a

sequence of stages that is related both to the age of the child and to the maturity of the parents. From this perspective, the generational conflict can be viewed as a stage in the process of self differentiation whereby youth seeks to further emancipate itself from adult authority by attacking that authority directly.

A conflict, however, never takes place in the abstract and always occurs in the context of particular issues. In this paper I want to suggest that a major source of issues for the generational conflict lies in the real or imagined violations of implicit contractual arrangements between parents

Dr. Elkind is Professor of Psychology at the University of Rochester, College of Arts and Science, River Campus Station, Rochester, New York 14627.

and their children. When parents violate such a contract their offspring usually interpret this breach as stemming from selfish motives on the part of the adults and hence experience violations as exploitation. It is this feeling of exploitation, or so it appears to me, which is one of the prime foci of the generational conflict whether it manifests itself individually in parent child quarrels and more dramatically in delinquent acting out or collectively in such movements as the student revolt.

To make this proposition concrete, I propose, in the first section of this paper to describe the development of parent child contracts in general and the major clauses of those contracts in particular. Then, in the following sections, I want to try and show how violations of these contracts can be related to two different manifestations of the generational conflict, namely, middle class delinquency and the student revolt. It is perhaps well to emphasize at this point that I am not arguing that the violation of contractual agreements is necessary and sufficient to explain the generational conflict. Far from it. What I am saying is that in Western society such violations have provided youth with at least some of the issues upon which to base their struggle for independence.

The Development of Parent-Child Interactions

One way in which the development of parent-child relations can be viewed is from the standpoint of the kinds of give and take arrangements that are explicitly or implicitly operative at all levels of development. At least three types of arrangements can be distinguished; the bargain, the agreement and the contract. Each of these types of arrangement needs to be dealt with in a little more detail.

The simplest and most temporary parent-child arrangement is the bargain. In the bargaining arrangement, the parent offers the child some reward or withholds some punishment in return for a particular behavior on the part of the child. To illustrate, when the parent offers the child a piece of candy if he will go to bed, this constitutes a bargain, a sort of one shot arrangement. A child, at least a middle-class child, soon learns to initiate his own bargains at a fairly early age. A child initiated bargain is illustrated by the following remark, "I'll get undressed and brush my teeth if I can stay up and watch *The Flying Nun*." Bargains change in their content as the child grows older, but continue to be viable means of socialization and inter-familial interaction.

A somewhat more complex, and more long lasting, arrangement is the agreement. In the agreement arrangement, the parents and child agree to abide by certain rules over an indefinite period of time. Agreements with young children often involve the threat of punishment, "If you hit your little brother again you will have to go to your room and miss the cartoons." which can be translated as, "If you agree to leave your little brother alone we agree to let you watch the cartoons." Like bargains, agreements change in their content as the child grows older but are present at all age stages of parent child interaction. In addition, whereas bargains appear to predominate at the pre-school levels, thereafter, agreements appear to become increasingly more prominent.

The most complex and least explicit parent child arrangement is the contract. A parent-child contract consists in the unspoken demands made by parents and child upon one another and which determine their mutual expectations. It is the sequence of parent-child contracts which

Because contracts are mostly implicit and are seldom verbalized directly, their existence often comes to the surface only in the breach.

most clearly reveals the developmental nature of parent child relations. Because contracts are mostly implicit and are seldom verbalized directly, their existence often comes to the surface only in the breach. The mother, for example, who says, "Look how they treat me after I worked and slaved for them," reveals her belief in an implicit contract as does the remark of an adolescent, "No matter how much I do around the house, it is never enough."

The contracts written during the major periods of growth; infancy, pre-school, childhood proper and adolescence, all have particular contents characteristic of that epoch. In addition, the contracts at whatever age level also appear to have at least three invariant clauses—compensatory demands between parents and child. These clauses are; the responsibility-freedom clause, the achievement-support clause and the loyalty-commitment clause. In the following paragraphs the content of these clauses at different age levels will be briefly described.

During each of the four major growth periods, the parents demand that the child accept particular responsibilities while the child contracts for complementary freedoms. Parents generally require very little in the way of responsibility of an infant and the infant, in turn, asks for little in the way of freedom. During the pre-school period, however, parents begin to demand that the child take responsibility for feeding and dressing himself, for bowel and bladder control and to a certain degree for emotional behavior. Children on their side, ask for some of the freedoms

made possible by their new mobility and motor control. They demand free access to the various rooms of the house, for crossing the street, and to handle tools and mechanical devices. In childhood, the responsibilities required of children become even more diverse and they are asked to look after their clothing, their rooms and their younger siblings. Children in their turn, demand new freedoms in the way of staying away from home for longer periods and for going further away from home. Again in adolescence, the contract is once more rewritten as parents request that young people take responsibility in the areas of sex, money and cars and as the teenager asks for new freedoms in the way of late hours, dress and friendships.

A similar developmental course is taken with respect to achievement and support. Parents demand little of the infant in the way of achievement other than that he walk and talk at the usual ages. The infant demands some emotional support for these achievements but such skills are largely self reinforcing. During the pre-school period, however, parents begin to make demands for achievement in the way of bowel and bladder control, linguistic prowess and social behavior. For his part, the child asks that the parent praise his accomplishments and devote time to supervising and instructing him. As the child enters school, parental demands for achievement come to center upon the three major areas of academic performance, athletic skill, and social popularity. In return children make complementary demands for material, intellectual and emotional support for their activities. During adolescence, parents intensify their demands in these areas and young people correspondingly escalate their requests for material, emotional and intellectual support. Parents of adolescents are sometimes fooled, by the prominent mone-

tary demands of this age group, into believing that their offspring are no longer interested in the more psychological forms of support. This is not in fact the case and psychological support from parents is perhaps more necessary during adolescence than at any other time.

Finally, in the area of loyalty and commitment, a developmental progression is equally discernible. Parents usually demand little from the infant in the way of loyalty other than that he respond to them positively and with affection. Likewise, the infant appears only to request that the parents be committed to their care taking function. As the child grows older the loyalty commitment clause begins to shift its focus. During the pre-school period parents demand that the child maintain his loyalty and affection for them in the face of his exposure to new adults such as nursery school teachers and baby sitters. The child, in turn, asks that parents maintain their commitment to him as new chil-

In adolescence . . . parents ask loyalty to their beliefs and values while the young person demands that parents be committed to the beliefs and values which they espouse.

dren are born into the family and as he makes new and greater demands upon their time and energies. Once the child enters school, parents generally require that loyalties to his family supersede his loyalties to the teacher and peer group. On his part, the child demands that parents give evidence of their commitment to him primarily in terms of the amount of time and interest they devote to his endeavors. In adolescence, this loyalty commitment clause takes on a still another coloration as parents ask loyalty to their beliefs and values

while the young person demands that parents be committed to the beliefs and values which they espouse.

This all too brief sketch of the development of parent-child contracts may, nonetheless, suffice to illustrate both the age related character of these contracts and the pervasiveness of the clauses regarding responsibility-freedom, achievement-support and loyalty and commitment. Obviously this is a normative schema which holds primarily for intact, middle class families in America. While I believe that parent-child contracts are written in families at all socioeconomic levels and in all cultures, the nature of the contracts and the invariant clauses they entail will necessarily vary in importance, if not in kind, for boys and girls and for different socioeconomic and cultural groups.

Contracts and Delinquency

As I suggested earlier, our knowledge of parent-child contracts often comes from those cases in which the arrangements have gone awry rather than from the cases in which the contracts have been honored. As so often happens, the exceptions illuminate the rule. My own awareness of the importance of parent child contracts come from my work with middle class delinquents.² In that paper, I discussed the role of contractual violations in the production of delinquent behavior. My aim here is not to recapitulate that discussion but rather to expand it and to differentiate between two different ways in which parents can exploit children and to describe the different patterns of delinquent behavior which seem to result.

When a parent ignores the contractual obligations imposed by the child's age and demands behaviors which are either above

or below the child's actual level of maturity we can speak of developmental exploitation. Parents, for example, who overprotect their children have in effect not only demanded inappropriate behaviors but have also offered inappropriate freedoms, supports and commitments. Contrariwise, parents who provide freedoms, support and commitments which are too advanced for the child's level of responsibility, achievement and loyalty have also failed to meet their contractual obligations and engaged in developmental exploitation. In such cases the parents are often too rigid or too anxious to flexibly adapt their behavior and expectations to the child's constantly changing powers and abilities. It is, therefore, the parents' inability to cope with their child's growth that lies behind their attempts to unduly impede or accelerate his development.

Exploitation, however, can also occur when the reciprocal demands of parent and child are appropriate to the child's age level. In such cases the exploitation results from a quantitative rather than qualitative violation of the contract and which might be called egocentric exploitation. We encounter egocentric exploitation when the responsibilities, achievements and loyalties required of children are appropriate for their age level but are requested in excess of what is reasonable or are demanded when the parent fails to provide the complementary freedoms, supports and commitments. Such exploitation is egocentric because in these cases the parent sees his own needs and problems as more important than those of his children.

In my work with middle class delinquents I have observed what appears to be a reasonably close relationship between developmental and egocentric exploitation and two phenomenologically different varieties of delinquent behavior. Among mid-

dle class adolescents who get into trouble with the law are those who are clearly emotionally disturbed and have internalized conflicts of long standing. On a purely descriptive level, these youngsters usually engage in delinquent behavior alone or with someone appreciably older or younger than they are. The act itself is frequently symbolic and bizarre (shooting up a school, molesting young girls and so on). Young people of this kind tend to be authority rather than peer oriented in their moral and social judgment and are, moreover, generally immature in their interests and choice of companions. In cases of this sort I have frequently found a history of developmental exploitation on the part of the parents wherein either the mother or father, and not infrequently both, treat the child as younger or older than his true level of maturity.

In contrast to such neurotic youngsters in whom unconscious feelings of exploitation sometimes find expression in illegal acts, is a much larger group of young people in whom the feeling of exploitation is quite conscious and clearly tied to parental behavior. Phenomenologically speaking, such adolescents are quite easy to distinguish from the neurotic youths. First of all, they usually get into trouble as a member of a group and seldom do so while acting alone. Their delinquent actions are, moreover, of the more or less conventional variety in the sense that they steal cars, become truant, act out sexually, or run away from home. They are, in addition, peer rather than authority oriented which is to say that they will not, for example, tell on friends whom they see engage in delinquent actions, and respect peer ethics and standards rather than abstract adult value systems. Such young people, generally have interests and friends appropriate to their age level. Again, in many of the cases of this sort

which I have seen, the pattern of parental exploitation has been of the egocentric rather than of the growth variety. Parents of "socialized" adolescents are found either to be demanding behavior in excess of what is reasonable or, on the contrary, to be remiss in fulfilling their part of the parent-child contract.

In summary, then, clinical experience suggests that the way in which parents exploit children, either developmentally (by demanding behaviors inappropriate to the child's age level) or egocentrically (by demanding excessive or uncompensated amounts of age appropriate behaviors) is related to two different varieties of delinquent acting out behavior. This is, to be sure, a relatively gross observation and we need to find ways of measuring these different patterns of parental exploitation and of relating them systematically to our diagnostic categories of adolescents who become delinquent.

Exploitation and the Youth Revolt

In the preceding section it was argued that parental exploitation on the part of individual parents could lead to delinquent behavior by their offspring. Exploitation is, however, not always an individual matter and some forms of exploitation are widespread and are fostered by the socioeconomic conditions prevalent at the time. There are, in other words, likely to be institutionalized forms of parental exploitation in the sense that most parents will engage in it, not because of individual quirks of personality but rather because such exploitation is considered socially appropriate and is socially sanctioned.

Before the passage of child labor laws, for example, developmental exploitation was socially sanctioned and children were expected to work as hard and for as long

hours as were adults. In recent years, institutionalized developmental exploitation has moved to the other extreme and society today tries to keep youth out of the labor market long after it is capable of productive work. Egocentric forms of exploitation have also become institutionalized at certain periods in history and such institutionalization has frequently emphasized one or another of the clauses of the parent child contract. In earlier decades of this century, for example, parents demanded considerable responsibility on the part of their children who were expected to help on the farm or in the family business or to be wage earners who contributed to the family income. Young people were not, however, granted the corresponding freedoms and had to fight parental prohibitions against living alone or befriending whomever they wished. This imbalance in the responsibility-freedom clause is still very much an issue in the generational conflict in the smaller towns of the Midwest and South today. A carryover of this form of institutionalized exploitation is the fact that the draft age is 18 while the voting age is 21*. It is a nice example of how society can demand responsibility without providing the corresponding reciprocal freedom.

In the urban areas of the Northeast and Far West, however, the focus of institutionalized egocentric exploitation no longer centers upon the issue of freedom-responsibility. Freedom for adolescents in the suburbs and cities is hardly a sore point today when owning cars, keeping late hours and taking overnight trips is generally accepted as part of the youth culture. Nor are parents as concerned about social responsibility. It is not just the "pill" and the

* The voting age has been lowered since this paper was written. The constitutionality of the new law is still to be tested.

knowledgeability of modern young people in matters of sex and contraception, however, which has made responsibility less of an issue. Rather it is the general sophistication of youth today which is often greater than that of their parents and which often makes parents embarrassed to impose restrictions.

If responsibility and freedom are no longer a point of contention between par-

Behind the demand for student power, and the turning on and tuning out, lies youth's resentment at an adult society that has been looking out for itself and which has forsaken youth's future for its own immediate good.

ents and adolescents the loyalty-commitment clause of their contract most certainly is. What young people feel today is that adult society has not lived up to its obligations to youth and consequently they feel no reciprocal need to be loyal to the values and beliefs of that society. Youth sees this lack of commitment all about it: in the form of a war fought more for pride than for justice and at the expense of youth; in the credibility gap; in the revelation of the extent of social and racial injustice; in the pollution of the air and waterways and in the disgrace of our cities. Behind the demand for student power, and the turning on and tuning out, lies youth's resentment at an adult society that has been looking out for itself and which has forsaken youth's future for its own immediate good.

This shift in the major issue of generational conflict in a large segment of middle class society may also help account for the Douvan and Adelson¹ finding that the angry battles between parents and youth which occurred in earlier decades is much

less prevalent today. This change in the overtness of the parental child conflict makes a certain kind of sense if we assume that in earlier decades freedom-responsibility was the issue whereas currently it is on the grounds of loyalty and commitment. When youth fights for additional freedoms, the goals are specific and concrete and both victory and defeat are clear cut. Not so when the issue is loyalty and commitment. Parental granting of freedoms is a relatively easy affair compared to an alteration of their commitment to youth. Young people know this. They are aware that demanding that their parents take a stand can never succeed and is a senseless battle.

It is in the context of this sense of futility in battling parents that I think many of the group youth revolts, which are both direct and indirect reactions to authority in general, must be understood.

To be sure, youths' charges against adults contain a certain amount of exaggeration and distortion. Youths' charge, for example, that adults are materialistic in their values lacks perspective. For the most part middle class youth of today have grown up in relative affluence and the concerns about getting a good job and making a good living which motivated their upward striving parents seem foreign and a little despicable to the children. Young people today take it for granted that they can get a good job and make a good living and cannot conceive of their parents' anxieties in this area. Likewise, youths' belief in the lack of adult commitment to future generations is probably not the whole truth. In many cases it is probably more true that values have undergone such rapid change in the last twenty years, as far as young people are concerned, that many parents don't really know where they stand on many moral and social issues. They cannot continue to abide by the values accord-

ing to which they were reared nor can they really accept the new value system. Youth mistakenly interprets this vacillation as a lack of concern with their welfare and translates a genuine "I don't know" into "I don't care." In fact, however, it is often because parents do care that they have tried to avoid imposing outdated demands upon their children.

In summary then, the issue which seems to stand at the forefront of today's institutionalized generational conflict centers around the loyalty-commitment clause of the youth society contract. Whereas youth has always been critical of adults for not really being committed to, or living according to, the values and beliefs they espouse, what is new today is youth's feeling that adult society has no real commitment to youth and to forthcoming generations. Hence youth will no longer trust adults to determine their future and want to take

part in the planning of their education and in the direction of government. As always youth has gone to the heart of the weakness in adult society. Since, however, the generational conflict is a growth process in which both youth and adults participate it can be a healthy force for change in the society at large as well as a mechanism of growth for youth. And, if adults feel harried and under attack by youth, they can take consolation in the fact that the current protagonists of the generational conflict will one day feel perhaps even more venomous barbs from the verbal onslaughts of their own offspring.

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Henry H. Weiss, Ph.D.

Evan F. Pizer, M.D.

Hospitalizing the Young: Is It For Their Own Good?

The authors question the advisability of hospitalization for children and adolescents, arguing that their admission for treatment may have long term deleterious effects on them. Among these are the stigma attached to hospitalization, the impact on self-concept, reduced opportunities for future self-determination and the possibility of diminished social competence. Juveniles should not be denied hospitalization for treatment when indicated, but this action should only be taken after careful deliberation of all the consequences.

Admission to inpatient status of children and adolescents has increased sharply in recent years. It has been estimated that resident patient populations are expected to decrease for the population 25 years and over, but increase by sizable amounts in the age groups under 15 years and 15-24 years. There were more than 5,000 children and adolescents under age 15 in state and county mental hospitals in 1963, and it is estimated this will increase to over 13,000 by 1973.⁷

Children and adolescents are admitted to state hospitals through a mutual selective process involving a sponsoring com-

munity agent and the hospital authorities. It is understandable that there is sometimes misapprehension and disagreement about some fundamental issue such as the purposes of child-adolescent units in state hospitals, mental health needs of children, the nature of childhood psychopathology, and what constitutes treatment or remediation. Differences of opinion about legitimate uses of state hospitals also exist. Some believe that using an adolescent ward as a detention facility is a lesser evil than housing a juvenile in a county jail. Temporary or short term hospitalization is considered appropriate to provide a respite for the family during a period of crisis until tensions diminish. There is also a question about the extent to which juveniles are admitted to a state hospital on the basis of a positive choice rather than by default.¹

The authors are with the Bureau of Mental Health, Division of Mental Hygiene, Department of Health & Social Services, 1 West Wilson Street, Madison, Wisc. 53702.

MENTAL HYGIENE

Miller and Kenney conducted a study of adolescents admitted over a period of three years to the inpatient service of a psychiatric hospital, with the focus on the relevance of psychiatric services. An examination of their population revealed they could divide their admissions into two broad groupings based on reasons for admission and psychiatric status. The larger group was referred for delinquent behaviors or as being at odds or in difficulty with the community. These adolescents were not seen as requiring or benefiting from psychiatric intervention, at least in an inpatient hospital setting. The non-delinquent group, whose admission to the hospital was judged as appropriate, were "referred on a markedly different basis, with specific descriptions of symptoms and usually without a sense of urgency on the part of the source."⁸ Increased admissions of adolescents were seen as stemming from a lack of understanding about what psychiatry could and could not do, unrealistic expectations of the community, and the failure to differentiate social from psychiatric problems.

It is not the view or intent of the authors of this paper that children and adolescents who should be hospitalized, and can benefit from hospitalization, be denied such care and treatment. However the position taken here is that the hospitalization of juveniles ought to be viewed as a momentous event, one with much potential for harm, and one not to be undertaken casually or lightly. Those with the authority to admit, should carefully consider the possible disadvantages and dangers of admitting juveniles to psychiatric hospitals, and weigh short term advantages against the possible lifelong consequences of hospitalization.

The chief dangers of hospitalization of children and adolescents are the development of a negative self-concept, reduced

social competence and coping skills outside the institution and, most importantly, falling victim to social stigma and its correlates of rejection and reduced opportunities for self-determination.

For more than a decade there have been attempts to carefully document social deterioration associated with hospitalization. The general thesis is that much of the deviant behavior of chronically institutionalized patients develops subsequent to hospitalization. While Gruenberg has pointed out that the development of what is called the social breakdown syndrome is first manifested prior to, and is a common justification for hospitalization, the progressive development of chronicity is independent of any particular mental disorder.⁴ The term 'institutional neuroses' is another concept that has been used to characterize the behavioral and mental changes that may result from institutional life.² The notion is that the very circumstance of institutional living, especially the quality of relationships among patients, and between

One has good reason to suspect that the term "voluntary admission" is an ironic semantic ploy since it is not likely that the juvenile is doing the volunteering.

patients and staff, leads to deterioration of social functioning which furnishes further reason to maintain a person in the hospital.

In a study of retardates, Cain and Levine compared the effects of a community with institutional school programs on trainable mentally retarded children.⁵ They found that children in the community improved while institutionalized children decreased in social competence. The quality and kinds of behavior that institutionalized children may develop are not in keeping

Rejection by society is frequently cited as the major negative side effect of hospitalization in a mental hospital.

with the modes of social skills and interactions required in community life. The extent that these concepts apply would, of course, be related to the length of hospitalization, and is probably not a danger for short periods of inpatient care.

Rejection by society is frequently cited as the major negative side effect of hospitalization in a mental institution. Kenefick has put it this way: "To call a person a 'delinquent' or a 'schizophrenic' is to set in motion usually a number of wheels and millstones which can as easily grind the patient as the 'disease' itself, even if the only person who 'knows' the diagnosis is a therapist. . . . More perniciously, in a larger context, it may involve social processes that have evolved to deal with 'impossible cases' . . . : and these, at best, then add to the original diagnostic terms of even more crushing social meaning, such as 'ex-con,' 'former patients,' and so on."⁸ In an opinion of the Supreme Court of Wisconsin concerning the rights of a juvenile on a finding of mental illness, the point was made that "Despite protestations to the contrary, the adjudication of delinquency carries with it a social stigma. This court can take a judicial notice that in common parlance 'juvenile delinquent' is a term of opprobrium, and is not society's accolade bestowed on the successfully rehabilitated."¹² Similarly, children and adolescents who were formerly mental patients may well become the objects of fear, distrust and suspicion.

The proposition that the very act of labeling a person sets them forth on a career of mental illness has been made by, among other sociologists, Scheff.¹¹ He

argues that the major consideration is not the quality of the behavior of the individual, but rather that the act of labeling a person mentally ill establishes the basis for the fulfillment of what the label implies.

The powerful role that a label plays, apart from particular behaviors of people, has also been pointed out by Phillips.⁹ He examined the effects of seeking help for problems of disturbed behavior "to determine the extent to which attitudes toward an individual exhibiting symptoms of mental illness are predicated on knowledge of the particular help source that the individual is consulting." He discovered that individuals described as exhibiting identical behaviors are increasingly rejected if they are described as utilizing no help, utilizing a clergyman, a physician, a psychiatrist, or a mental hospital.

. . . much of the deviant behavior of chronically institutionalized patients develops subsequent to hospitalization.

In a review of empirical research covering the past two decades of attitudes toward mental patients conducted under the auspices of the Wisconsin Association for Mental Health, Johannsen⁵ confirmed that being known as a mental patient carries a serious stigma. "The over-all view is grim; and the mental patient, usually defined as someone who has had some contact with a mental hospital, is treated with fear, distrust, and dislike. Only a little distinction is made between a neurotic and psychotic person." When the mental patient label is not imposed, society is likely to be tolerant of a great deal more aberrant behavior, often regarding symptoms as mere signs of eccentricity which confirms Scheff's view that the label mentally ill has greater impact than one's actual behaviors.

He also confirms that society is quite tolerant of deviant behavior as long as it is not labeled a manifestation of mental illness. And in support of Phillips' finding he reports "there is noticeably less stigma attached to having been in psychiatric treatment than having been in a state hospital."

Development of a negative self-concept has often been cited as a consequence of hospitalization which may lead to the fulfillment of the prophesy implied by the judgment. The child hospitalized and thereby labeled may easily persist in his belief that he is peculiar and different because he has been so regarded by an expert, a doctor, who ought to know. He takes upon himself the negative connotations attributed to the mentally ill: "When the patient is officially classed as a mental patient, perhaps by being placed in a mental hospital, perhaps by commitment, and is handled as mentally ill by the "direct and implied attitude of physicians and the whole treatment setup, all of this is impressive to the patient, and he will tend to adopt it as his own view of himself."¹⁰

Ironically an aftermath of hospitalization imposes a psychological burden upon those less able or equipped to carry one, namely how to relate the fact of hospitalization in various situations which come up during the course of one's life. The formerly hospitalized juvenile is often thrown into a quandary when he must decide whether to acknowledge that he has been in a mental institution. The issue is not a matter of practical judgment alone, but of conscience which touches one's moral being and thus becomes a source of stress. When the topic crops up it is not usually in casual circumstances but at a crucial point in one's life. We refer here to employment, the military, application for a

driver's license, and the proposal of marriage.

The case of enlistment may be of special import. For some the opportunity for military service has much significance. It is a chance for a new start, to prove one's self, and to learn. The service can provide escape from an unsatisfying life or to give one a breather, the chance to mark time and consider one's future at leisure. The opportunity for military service and its potential benefits may well be blocked for the formerly hospitalized juvenile.

The formerly hospitalized juvenile is often thrown into a quandary when he must decide whether to acknowledge that he has been in a mental institution.

A person is also confronted with his past when he completes application forms such as a driver's license. It is usually necessary for the previously hospitalized person to obtain a certificate to the effect that he is recovered, or has been released unconditionally. Otherwise he must submit to a special examination.

What does one tell one's friends and intimates? Does one inform the girl to whom he wants to propose that he has spent time in a psychiatric hospital, i.e., is a former mental patient? The stress and inner turmoil these moments of truth may engender should not be minimized.

What precautions can be taken to lessen the realization of the concerns expressed in this paper. A preliminary consideration is motivational since decision-makers will act in the absence of external pressures only if they believe the reasoning and evidence cited has merit. If the reader is so persuaded, a policy review and the development of clear guidelines is called for. Among the points recommended for in-

clusion should be 1) that admission of juveniles to inpatient status be on the basis of a positive choice, i.e., clinical findings clearly indicate that the condition justifies admission, and 2) the institution has the resources to treat the child. Conversely, the mental hospital should not be used as a dumping ground for juvenile rejects whose condition is primarily a manifestation of social pathology rather than mental illness. In this regard one has good reason to suspect that the term 'voluntary admission' is an ironic semantic ploy since it is not likely that the juvenile is doing the volunteering. Parenthetically one of the arguments for the hospitalization of certain adolescents creates a paradox. While acknowledging admission of some juveniles as inpatients is inappropriate, it is justified on the basis of a lack of adequate alternative living arrangement in the community. Yet the very act of hospitalizing these people serves to reduce pressure, thereby lessening the demand for, and forestalling the creation of, substitute resources.

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Henry P. David, Ph.D.

Mental Health and Social Action Programs for Children and Youth in International Perspective

Forty countries were surveyed in 1968 in an effort to gather information on innovative services for emotionally disturbed children, retardates, juvenile delinquents, and the culturally deprived. Special consideration was given to the organization and delivery of services, the contributions of non-professional manpower, and preventive endeavors. The author summarizes trends in various countries and notes the benefits and experience gained with group care and non-professional staff.

Cultural Deprivation and Group Care

As noted by Eisenberg,³ one of the major issues facing mental health specialists and others caring for children is the "deprivation syndrome." It is, in varying degrees, a complex of intellectual retardation, personality defect, and social maladaptation, generally produced by the unavailability to the child of the biosocial necessities for normal growth and development, usually as a consequence of gross social pathology.

Worldwide evidence reflects the significant correlation between economic deprivation and maternal ill health, poor pre- and postnatal care and malnutrition, and the predictable results. Deprived youth receive little intellectual stimulation at home, are barely motivated to attend school, and must crowd into inadequate classrooms. They tend to live in decaying neighborhoods, rich

Dr. David is Associate Director, International Research Institute, American Institutes for Research, 8555-16th St., Silver Spring, Md. 20910.

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only in opportunity for trouble and characterized by value systems opposed to those of the dominant culture. Rates for parental disorder, death, and desertion are high. Such children become premature and inadequate parents themselves, fated to repeat the cycle of deprivation for a succeeding generation.

The concept of substitutes for parental care is not new. Examples may be found in all modern societies. The Western world,

differences both in social attitudes and in the alertness of children, depending on how early they are placed in institutional type care and how much they have been deprived of parental attention and family life.

To be accepted in a society, a children's institution must establish its "legitimacy" as a social structure. The prevalent view of most North American institutions is that they are deviant settings for child rearing, claiming to work primarily with problem

... the basic barriers to the improvement of child care are socio-economic ...

strongly influenced since the turn of the century by Freudian concepts and a laissez-faire philosophy, has leaned toward substitution in the form of individual child care in foster homes. Manpower shortages, tight housing conditions, and high employment rates among women, as well as ideological considerations, have tended to favor group care in the predominantly Catholic lands of Europe and Latin America; in Israeli collective settlements (kibbutzim); and in the socialist societies of Eastern Europe.

There is considerable variation among Eastern European group care programs. Meers and Marans⁶ observed that some babies are placed directly in residential institutions, e.g., special facilities established for children of graduate students at universities. Children of working parents may spend five days a week in an institution and the weekend at home. Other youngsters go directly to the nursery from about three months of age onward; they continue in day care throughout their preschool life. Because of competition for available space in the day care centers, some children are not placed until they are two or three years of age. It is Meers' impression that there are

children, the dependent, neglected, delinquent, retarded, and emotionally disturbed. They may be called "training schools" or "hospitals" whose goal is the successful return of the child to his natural family or a foster home environment. In sharp contrast, much of the impetus abroad stems from the ideological conviction that group care is superior to the natural family environment.

The North American reader of the literature may be troubled by an apparent similarity of many of the Eastern European programs to the kind of orphanages, junior republics, and church operated, or public, institutions which flourished in the United States several decades ago. Such analogies would be very superficial. In contrast to the "outsider" status of group centers in the United States around the turn of the century, group care abroad is a significant part of the mainstream of society. Prevalence of the kind of psychological deprivation reported by Bowlby, Spitz, and others appears to have been sharply reduced in most modern facilities. What is perhaps more troublesome is the absence of systematic longitudinal or other research data from the Eastern European programs. When

some indication of deprivation has been reported, it has usually been concluded that such retardation is minimal and can be reversed through later education, just as character structure and values of self and others are viewed as modifiable consequences of early education.

After noting the controversies and warnings, the question must still be asked whether, under conditions assuming adequate staff ratios and finances, infant group care is not an acceptable substitute for families crippled by economic and social disadvantage. Present U.S. research has amply demonstrated the vicious circle effect and damage to mental health under conditions of socio-economic and cultural deprivation, which affect nearly a quarter of U.S. children.⁶ Infant day care programs might open the way for breaking the self-propagating set of social tragedies for this population.

If the concept of a social need to innovate is accepted, are we prepared to make fiscal investments comparable to those incurred, for example, in the Soviet Union or Israel? Are we ready to recruit, train, and reward

turbid or rioting outcasts? Can we change deep-seated and powerful socio-cultural traditions?

Juvenile Delinquency

Among the most baffling social maladies of the century is that of juvenile delinquency. A worldwide phenomenon, it may vary qualitatively and quantitatively from country to country. In recent years Sweden had the highest rate of juvenile delinquency: 8% of its teen-agers passed through the courts (compared with 2.3% in the United States). Teen-agers commit over 20% of Japan's total crimes versus 12% in the United States. In Israel the number of arrested juveniles has doubled in the past decade.⁷

There is at least one significant difference between juvenile statistics in the United States and other countries. Nearly everywhere else, a youngster is brought to court only if he breaks a law which would also constitute a crime when violated by an adult. In the United States, the definition of juvenile delinquency has become so all-encompassing that children enter the statistical records for truancy, stubbornness, leaving home, curfew violations, etc., none of which would be termed a law violation in other lands.

In working with delinquent youth (regardless of legal definition or terminology) there appears to be near global consensus, emerging from numerous international seminars and conferences, of the desirability of bringing a more therapeutic-rehabilitation orientation to correctional institutions. However, observations of juvenile centers also reflect the considerable divergence existing between institutional aspirations and actual practices, requests for staff and operating personnel, and innovative treatment concepts and implementation. Rec-

In the United States, the definition of juvenile delinquency has become so all-encompassing that children enter the statistical records for . . . violations that would not be termed a law violation in other lands.

adequately more child care staff of merit and dedication? Can we produce the conditions that will give status and recognition to those working with disadvantaged children before such youngsters become dis-

ommendations for coping with resistance to perceived threats to existing staff structures and institutional methods of control are widely discussed.

Although extensive surveys have been conducted and reports written, it is virtually impossible to offer a precise estimate of the extent to which mental health principles have actually penetrated work with delinquent youth. There are considerable differences between countries and between types of institutions within any one nation. Nearly all reflect some dissatisfaction with progress made so far. Countries which compared to others have high staff:inmate ratios and a complement of mental health specialists are no more content than countries still aspiring to such levels.

Ideology enters the picture in determining how a given society deals with delinquency. In some cultures, notably the United States, a relationship between cultural deprivation and/or mental disorder and delinquency has become well accepted. There is public demand for more and better professional services. In sharp contrast, the Soviet view is that a delinquent lacks the kind of moral education essential for honest participation in a communist society. As Conrad¹ observed: "In the United States, the offender is likely to be an unfortunate person needing treatment. In the Soviet Union, he is an unfortunate person needing opportunities to learn."

After years of denying its existence, the Soviet Union now reluctantly accepts juvenile delinquency as a part of Soviet life, a social phenomenon ascribed to increased industrialization and greater affluence. But, there is frequent insistence that the problem is not as severe as in the West. After all, it is said, Soviet youngsters do not have easy access to automobiles, cannot readily purchase guns, and are unable to shirk

socially useful labor without attracting the attention of authorities. Assuming that, in fact, the U.S.S.R. does have a lower rate of juvenile delinquency than most other industrial countries, it would be most worthwhile to study the extent to which these differences may reflect upbringing (such as in a collective), the effects of contemporary social conditions and changing family values, and a new kind of Soviet affluence. Soviet pedagogues maintain that pre-delinquent behavior can be handled more effectively by the combined help, censure, and pressure of the peer group in the collective than by professional mental health workers.

When it comes to "doing something" about juvenile delinquency, the literature reflects a plethora of approaches, from individual psychoanalysis to severe punishment. It is also evident that many well-intentioned endeavors have had limited effect on the rising delinquency rate. Constructing housing developments and playgrounds, organizing boys' clubs, reducing the number of working mothers, mending broken homes, and sending everyone to child guidance clinics have not, in themselves, had far-reaching effects. The experiences reported from Denmark, German Federal Republic, India, Japan, Sweden, Soviet Union, Canada, Philippines, Switzerland, Israel, Turkey, Austria, England, Poland, and Yugoslavia suggest that an impact can be made by providing meaningful jobs, lowering the school-leaving age for those entering vocational training programs (e.g., 14 years in Denmark), and by qualitatively strengthening the youth work of the police, parole, and volunteer agencies. Particularly effective have been the pedagogic-therapeutic programs in Denmark and the Federal Republic of Germany; the therapeutic use of work and vocational training in the Soviet Union and Canada; and the enlistment of volunteers in pre-

ventive endeavors in Turkey, Poland, and Yugoslavia.

Effective delinquency control is something that requires constant attention. In many parts of the world, particularly in the collectivist societies, large groups of citizens appear to be far more involved in preventive work than is the case in the Americas. Good probation, small institutions, adequate school counseling and curricula, better police and understanding judges can rehabilitate troubled youth. Tunley⁷ reported that many communities abroad, less fortunate economically than the United States, spend a far greater proportion of income on child welfare. Following his global survey, he recommended: (1) having available a variety of work and training opportunities which will keep youngsters off the streets and busy at something they like and believe has a future; (2) revision of school laws to allow certain students to leave earlier and/or adding vocational work programs into the schools; and (3) spending more money for more adequate probation, police, and court services along with smaller rehabilitation units.

The impression which emerges from the literature and from personal observations is that good ideas may be found in many parts of the world. Often they have been developed by and are dependent on key people who have attracted highly motivated followers but have failed to inspire imitative programs either in their own lands or abroad. It seems that in the field of correction change is more difficult to achieve by directive or example. Though change may be advocated by administrators, those involved in daily operations tend to be more concerned with problems of control and with restrictions. Change *per se* is feared and often misunderstood. The evidence suggests that neither the variety of available services nor the increasing so-

phistication of pioneering programs have thus far had a marked effect on the worldwide rise in delinquency.

Manpower Trends

The recognized shortage of professional and non-professional mental health and child care workers is global. It is particularly acute in residential facilities, whether for emotionally disturbed, delinquent, or deprived youngsters. Many European residential homes, schools, and observation centers are staffed by a small number of professional workers and a larger number of child care workers whose titles may be *educateurs*, *orthopedagogues*, house parents, or specialized teachers. It is they and their activities that create a center's therapeutic or non-therapeutic atmosphere. Although many directors of institutions regularly impress their visitors and government officials with a desire for more formally trained workers, there is often evident satisfaction with the existing staff, many of whom are self-taught. Their attitude and their success or failure to implement the director's policies are basic to the institution's milieu.

The treatment model in most American children's centers places primary emphasis on diagnosis, case work, and group and individual therapy conducted by professional workers. As noted by Linton,⁴ the professionals furthest removed from the daily life of the child have the highest status and rewards, as well as control over the prescribed regimen; those individuals with the closest personal contact with the child and his actual behavior frequently receive the lowest status and the poorest rewards for their work. One reason for this situation is that the American model emphasizes psychological and pathological aspects of behavior. In both theory and

practice the importance of psychological understanding is stressed. The medical model prevails, with other disciplines formulating their treatment approaches in conformity with that concept. While an individual worker may achieve a high level of accomplishment in selected facilities, child care workers, as a group, have not attained high visibility, status, or recognition in the United States.

In contrast to American practice, newer professional roles have emerged more rapidly in Europe. Particular attention is focused on "educateurs" in France and "ortho-pedagogues" in the Netherlands. The training of educateurs has been well developed in France for more than two decades; the graduate educateur is in considerable demand throughout Europe. He is perceived as a member of an independent discipline, not subordinate to medicine, psychology, social work, or education, nor is he especially trained in diagnosis or therapy.

He is neither a teacher, expected to raise a maladjusted child to a particular academic level, nor a houseparent or attendant who attempts to control the behavior of his wards. Rather, the educateur is a highly trained professional youth worker who is primarily concerned with the total life process of the individual youngsters in his group. He is prepared to utilize all the leisure moments of the child's life, and to program this free time so as to facilitate physical, moral, social, and intellectual development.

In many French institutions for disturbed children, as well as elsewhere on the continent, educateurs are the key figures in the total life space of children; they are deeply involved in day-to-day reeducation and resocialization. Educateurs work in and frequently manage institutions for delinquents, retarded, physically handicapped,

... the professionals furthest removed from the daily life of the child have the highest status and rewards, as well as control over the prescribed regimen . . .

the socially and emotionally disturbed, the homeless and neglected, etc. They are also trained to function as street-workers in slum areas. While traditional professional roles of psychiatrists, psychologists, social workers, and teachers remain essentially the same, the difference lies in the fact that the daily management and direction of an institution is in the hands of an educateur-director and his staff of educateurs.

In much of the world the question of who qualifies for child care work, with what training, obtained in which kind of institution, is an open one. There is general agreement that some people would never be suitable for work with children regardless of length of training or quality of work performed. Others seem to work well without any specialized training. There is much discussion about the location of training programs, whether on the job or in a university or special school, or some sort of combination. There is debate on whether to require a watered-down version of professional training, operating from the same basic assumptions taught to professional disciplines, or whether to approach training from quite different perspectives. Much consideration is given to the contributions of volunteers, e.g., the *curateurs* in Poland and youth workers in Denmark and Yugoslavia.

Literature and personal observations reflect a growing conviction that those closest to the disturbed child's daily life have the greatest influence on reeducation and re-

socialization processes. The medical model is undergoing reexamination and the hierarchy of professional roles is being reconsidered. Perhaps the time has come for a more systematic transnational survey of who does what, where, and how, for which purpose, and with what results. Conjecture or uncontrolled imitation are less than adequate. The increasing shortage of skilled professionals amidst burgeoning demands for services calls for innovative enterprise. Are we prepared to change the status quo?

Conclusions

If there is a lesson about programs for culturally deprived youth and juvenile delinquents that can be conveyed from the material gathered for the (U.S.) Joint Commission on Mental Health of Children, it is that considerable improvement can be attained in nearly every country if we will only apply, or adapt, already available knowledge. There is much to be learned from the suggestions for extended social security and/or mandatory sickness insurance benefit schemes, effective group care for deprived youngsters, vocational training for school drop-outs, better police, court, and probation facilities, training of non-professional child care workers with more status and reward accorded for services of excellence, and encouragement of qualified volunteers. Implied in these recommendations is a recognition that the basic barriers to the improvement of child care are socio-economic, and that amelioration requires a departure from the exclusively medical model of child mental health services to one of socially shared public responsibility for children, with emphasis on strengthening individual assets instead of focusing on pathology.

In this time of rapidly shifting values and growing alienation of youth, it is essential to review where we have been and where we are going.² Statistics demonstrate starkly that many modern systems of organization and delivery of care, and of individual payment of services, are antiquated and fail to meet the health, education, and welfare requirements of large segments of the world's children. Direct comparisons are elusive. There are differing approaches and ideologies in diverse geographic regions. However, no one country, no one profession, and no one ideology has a monopoly on innovative programs. It is time to learn from each other, from our mistakes as well as from our successes.

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Anthony F. Donofrio, Ph.D.

Child Psychotherapy— Help or Hindrance?

The author discusses the diagnostic pitfalls psychologists encounter in dealing with children and urges a greater understanding of children's problems. These, he believes, can be grouped in three categories—problems arising from deprivation of basic psychological need, those arising from constitutional and developmental factors and those arising from minimal neurological damage or dysfunction. He proposes alternatives to child psychotherapy which include working with parents and other significant adults in the child's life.

Introduction

Twenty-two years of experience in child guidance clinics and private practice have convinced me that child psychotherapy is, for the great majority of children referred for that purpose, a hindrance rather than a help. Other authorities have come to a similar conclusion.

In his presidential address to the nation's psychologists, Nicholas Hobbs stated: "We have become increasingly convinced that a major barrier to effective national planning for emotionally disturbed children is the professional's enchantment with psychotherapy."⁶

Dr. Donofrio is Supervising Clinical Psychologist at Catholic Charities Mental Health Center, 44 Fifth Avenue, Bay Shore, N.Y. 11706. The views expressed in this paper are not necessarily those of the entire staff of the center.

Several studies conclude that child psychotherapy has not proven its effectiveness. Shepherd, et al.¹¹ at the University of London, attest to this conclusion. Fifty children from a school population were carefully selected to match the symptom picture of fifty children who were about to start clinic therapy. A follow-up study after two years showed almost identical percentages of improvement in the treated and non-treated groups. It appeared, then, that therapy was not demonstrably superior to the passage of time. Of further significance was the finding among the therapy group that the number of therapy sessions bore little or no relation to the status of "improved," "unchanged" or "worse." Neither could it be argued that those children showing most improvement on minimal treatment were those who were least

disturbed, because, of the nine clinic children originally rated "severely disturbed," eight were improved at follow-up but only two had received more than five sessions with a psychiatrist. Levitt⁸ summarized numerous follow-up studies on child therapy and concluded: "The present evaluation of child psychotherapy, like its adult counterpart, fails to support the hypothesis that treatment is effective. Another review by Lewis⁹ comes to a similar conclusion. Finally, Thomas, et al.,¹² in a ten year longitudinal study (from infancy) of temperament and behavior in 136 children, found parent guidance the effective method of helping child and parent; in very few cases did they consider psychotherapy useful. The average number of sessions undertaken per couple was 2.9.

Scope

In the sections ahead, we plan to treat first the diagnostic pitfalls for many psychologists upon whose evaluations the social worker, educator, and psychiatrist often rely heavily. The second aspect will describe three major categories comprising children's problems, namely those arising primarily from deprivation of basic psychological needs, those arising from constitutional and developmental factors, and those arising from minimal neurological damage or dysfunction. Finally, in view of our essential rejection of child psychotherapy, we will propose other concepts for the rehabilitation of the child in these three settings.

Psychomisdiagnosis

"One of the most puzzling and distressing problems that confronts clinical psychology today is the persistent report by many psycho-diagnosticians of clinical observa-

tions, which, by objective evidence, clearly appear to be erroneous."² The authors point up the failure of researchers to substantiate many of the diagnostician's interpretations of projective test responses. The agreement in interpretation, on the part of many practicing clinical psychologists, in the face of "massive negative experimental evidence," leads the authors to posit a "systematic error" in which said clinicians reinforce one another, resulting in an "illusory correlation." The authors conducted six studies to show the genesis of widespread but erroneous diagnostic interpretations.

From the vantage point of a psychiatric guidance clinic serving a large area with its many school districts, we heartily endorse the above indictment. Misdiagnoses with conformity in language or semantics are rife; the heavy reliance on projective tools whose interpretative validity is very questionable, indeed, distressing.⁵ One sees many parents confused and emotionally upset. Some have already been referred to private psychotherapists and are seen, later, financially and emotionally drained.

Our psychodiagnostic tools consist of "objective" and "projective" tests. The objective tests consist of measures of cognitive or intellectual functioning: attention, concentration, memory, perception, learning and subject achievement. These are the psychologist's most valid and reliable tools with which much important information can be gained about the child through the test results and the examiner's observations. Not infrequently, however, does one find only a paragraph on this aspect while a page or two of dire dynamics issue from the projective tests. That the mother protests her child is not emotionally disturbed, but "can't get his school work" is dismissed as coming from a defensive *ignominy*. *Too often has mother been in-*

tuitively right and the psychologist wrong. Marked variation in performance on the eleven subtests of the Wechsler Intelligence Scale for Children is typically attributed to "anxiety" or "emotional block" and psychotherapy recommended. More often

How often husband and wife have blamed each other, suffered cumulative guilt, and fallen into a vicious circle because of our professional misdiagnoses and blind-spots.

than not (along with Clement and Peters),⁴ we have found this untrue in our clinic experience—a cart-before-the-horse phenomenon. In the words of Hobbs⁶—"If a child feels he is inadequate in school, inadequacy can become a pervasive theme in his life. . . . Underachievement in school is the single most common characteristic of emotionally disturbed children. We regard it as sound strategy to attack directly the problem of adequacy in school for its intrinsic value as well as for its indirect effect on the child's perception of his worth and his acceptance by people who are important in his world. . . . School is the very stuff of a child's problems."

Much of the misdiagnosis of childhood problems by psychologists can be attributed to the lack of proper and adequate exposure to certain areas of child study. We refer to child, developmental, and constitutional psychology as well as the recent focus on minimal neurological damage or dysfunction. *The average practitioner is overexposed to, and overawed by, child analytic theory.* Barclay,¹ as a member of an APA committee on the training of psychologists reported finding that less than 10% of clinical psychologists "had any exposure to courses in developmental or child psychology." He also comments on the reluctance

of psychologists to diagnose mental limitation or retardation. We find too little credence given to a mother's knowledge of her own child's behavior.

Sources of Children's Problems

For didactic purposes, we have divided the sources of children's problems, seen in clinic and private referrals, into three categories. We are fully aware that in actuality these will overlap, but usually one of the categories can be assigned as the primary factor in diagnosis. There are those problems arising primarily from the deprivation of one or more basic psychological needs; those arising from constitutional and developmental factors; and finally those arising from the "sub-clinical" or minimal neurological damage or dysfunction.

We may posit four basic needs in the child: love or affection, security, recognition, and a sense of achievement or accomplishment. I would add a fifth—the need for a wholesome foundation in religion, particularly for its existential implications in adulthood.

Constitutional differences in children have struck me forcefully in the years I have served a foster home agency. There is the infant who "jumps out of his skin" when he drops a rattle on the examining table and who is sensitive to the many vicissitudes of weaning and rearing. In contrast stands the infant whom you can "rough up" and who comes back smiling all the time. One sees them as toddlers, advanced to the older nursery, the one shy and relatively unresponsive, the other friendly, forward, and of happy countenance despite the same setting. Thomas¹² and his coworkers have documented these differences in a ten year longitudinal study from infancy. They are extricating parents from the guilt engendered in them in

the past by psychoanalytic blindness to such innate factors.

The ignorance of developmental psychology in clinicians, pointed out by Barclay,¹ is seen when slow maturation is interpreted as "regression." Knowledge of developmental behavioral patterns, of "ages and stages," is indispensable. Without adequate

Help for the child's ego must come, therefore, via the education and guidance of the "significant adults" in fulfilling the needs of love, security, recognition and achievement.

knowledge of constitutional and developmental psychology, the psychologist is of little value—if not of actual harm—to parents.

The diagnosis of minimal neurological damage of dysfunction is relatively recent. One finds the analytically oriented professional poorly informed and often quite resistive in this area. The regular neurological examination is usually negative and the EEG may also be negative, yet converging evidence can be obtained from history, current behavior, and psychological test results. Behavior includes a number of the following traits: hyperactivity, distractibility, hyperexcitability, perseveration, awkwardness or poor coordination, marked immaturity, and a learning disorder. I would estimate that 30% to 40% of the referrals to child guidance clinics fall into this diagnostic category.

Programming vs. Psychotherapy

For the purpose of this paper, "childhood" can be considered to extend to the 11th year, where Gesell & Piaget agree on a major demarcation in the evolution of the ego. Piaget, in his intensive research

on the development of cognition, finds the beginning of the abstract, "future" oriented characteristics of adult cognition, at the 11th year. Gesell sees the equable and docile 10th year as really the end of childhood with glimpses of the adolescent in the 11th year; the ego is embarked on its course toward independence. The term Programming is borrowed from Redl and Wineman¹⁰ who point up the practical uselessness of psychotherapy in dealing with their disturbed aggressive children in the Pioneer House experiment.

If one grants the premise that a child's psychological well-being depends on the fulfillment of his basic needs, and that his ego is still in a dependent relationship, then how can one, or even two hours a week of expensive play or interview sessions truly serve this child's ego when in the other 167 hours, the significant adults in his life are often unwittingly blocking need fulfillment by omission or commission, by misconception and confusion.

Although we categorized in first place, "problems arising from the deprivation of basic psychological needs," we find in actual practice, along with Thomas et al.,¹² that this category rarely stands alone but is usually inextricably interwoven with the other two categories. We refer to the constitutional factors of the given temperament and developmental stages, and to minimal neurological dysfunction. It was from the "difficult" children (temperamentally) for the most part that Thomas et al. derived their "clinical" group—those whose parents needed guidance. The child who comes equipped favorably in temperament and constitution (includes intellectual efficiency) comes by much of his basic needs among peers and his significant adults almost automatically.

Programming for ego-building involves discerning or defining the child's tem-

perament, intellectual level and learning efficiency, developmental stage, and neurological intactness, and then furnishing concrete guidance to the significant adults in his life toward the goal of fulfilling realistically his basic needs.

How to recognize, accommodate to, and minimize the effects of difficult traits of temperament in the child is a task for parent and teacher. In this regard, *Your Child Is a Person*³ is an excellent contribution for both professional and parent. Problems arising from developmental factors, such as "maturational lag" with its concomitant school unreadiness, are rather easily solved if they are diagnosed parsimoniously as just that and not "emotional disturbance" or "overprotection." Two paperbacks (Dell) of the Gesell Institute, "Child Behavior" and "Parents Ask," and a recent publication of Ilg and Ames,⁷ are of immense value for guidance in this aspect.

How to help the child with a minimal brain damage is most challenging. He and his parents have been most misunderstood because his "crippling" is invisible. His coping mechanism is faulty; hence, his needs are excessive. If psychotherapy is not the answer for the child with an intact central nervous system, it certainly is not for the minimally damaged child. Correct diagnosis is of first importance—too many are misdiagnosed as neurotic children or latent schizophrenics. Parents need several sessions of education and concrete guidance; medication is often of much assistance. The school must adapt its program to his special learning difficulties to insure (in some measure) the fulfillment of the needs of achievement and recognition. Associations of parents of brain-damaged children are mushrooming throughout the country, seeking better programs of education and service.

Sunshine and Rain: While specific principles of guidance apply to each of the categories of children's problems, there is a basic principle which is crucial and transcends all conditions. In my guidance sessions with parents, I call it my "two to one ratio" or "Sunshine and Rain." A plant needs rain but much more sunshine to flourish. Just so, the child needs correction, scolding, punishment (negatives); but, more affection, humor, praise and recognition (positives) in a better than "two to one" ratio.

Condition of the Parents: How, we are thinking, can we effect a change in the child's behavior if the parents are neurotic and there are perhaps marital conflicts? First, I would draw attention to a factor so often overlooked by professionals in our field—the contribution of the child's behavior to the relationship between husband and wife. We refer to behavior based primarily on major constitutional or neurological deficits in the child. How often husband and wife have blamed each other, suffered cumulative guilt, and fallen into a vicious circle because of our professional misdiagnoses and blindspots. Even with neurotic disturbances in parents that antedate their parenthood, we have found that the child can be substantially helped with a clear diagnosis and concrete guidance, without attacking the mother's neurosis. Marital counselling and individual counselling for the parent are certainly worthy of attention concomitantly if feasible.

The Guidance Professional: What of the "condition" of the guidance professional? Love and compassion are necessary attributes. They do not come with the degree. Some portion of these attributes derive from knowledge of the human personality and some from humanistic and religious considerations. The importance of these attributes becomes clearer when

we reflect that a large proportion of our clients would fall into the category of the "less lovable"—often for reasons largely beyond their control.

While we have presented reasons for the elimination of child psychotherapy under eleven years of age, we do not intend any inference that we regard it as of primary importance above that level. "Programming" is still considered primary for the older child and adolescent; a brief period of psychotherapy may be secondarily helpful.

Conclusions

We have challenged the practice and the claims of childhood psychotherapy. We see it as essentially and practically useless, inextricably bound up with yet-to-be proven child analytic concepts, misdiagnoses and adu!tmorphic ambiguities. We see here a violation of the Law of Parsimony.⁶ In practice, we have seen many parents who have gone through the ordeal of a year or two of financial drainage, and compounded confusion. We suggest with Barclay¹ that graduate training schools re-assess their programs, and that the term and process of "Programming" be substituted for that of "Psychotherapy" for children—programming for ego build-up, through need gratification at the hands of the significant adults in the child's life. We do not agree with the hue and cry for more psychiatric clinics for children. What we have will suffice when "professionals' preference for deep explanations (psychoanalytic) and derogation of all else as superficial"⁶ is replaced by the proper scientific stance of

the Law of Parsimony; i.e., where one or more explanations are at hand, we must accept the simplest first.

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James K. Whittaker, Ph.D.

Training Child Care Staff: Pitfalls and Promises

The author outlines procedures for the training of child care workers. This can range from life space supervision in which the supervisor demonstrates techniques, to one-to-one supervision in an office setting to group supervision. All members of the staff, from the janitor to the administrator should participate in training.

This paper will attempt to outline a number of specific guidelines for the establishment of a child care training program, as well as explore several potential pitfalls inherent in undertaking such a venture.*

To begin with, we must ask ourselves the question: "Training for what"? It goes without saying that what the child care worker does in an institution should be based, in large measure, on the problems and needs of the children in his care. Too often, what the child care worker does has more to do with organizational expediency, or with professional needs, than with the needs of the children. It would appear that, whichever professional group occupies the position of leadership in an institution, a great deal of time and energy is spent in maintaining rigid status hierarchies and

role distance between the various professional groups. It has reached the point where the quality of an institution is often judged solely on the number of different specialists which it employs. In the course of a single week's time, the child might be expected to see his: psychotherapist; group therapist; family case worker; occupational therapist; recreational therapist; music therapist and so on. We expect this of the child, despite the fact that relatively few problem children come to the institution with such neatly encapsulated and well defined problems.

In such an institution the child care worker's role would actually consist of little more than that of a good traffic manager, who makes sure the child is ready for his string of daily appointments. Training child care staff would probably cause problems in such an institution, since the indi-

Dr. Whittaker is an associate professor of social work at the Univ. of Washington, Eagleson Hall, 1417 N.W. 42nd St., Seattle, Washington 98105. This article is adapted from a paper presented at "The Other 23 Hours of Treatment" Institute held at the Nolte Center for Continuing Education, University of Minnesota, August 7, 1969.

* Based on the author's clinical experience as assistant director of the Walker Home for Children in Needham, Massachusetts and as a member of the senior clinical staff of the University of Michigan Fresh Air Camp.

vidual child care worker would not be allowed to do anything. A far more fruitful approach would be to begin with the problems of the children in care and to design the child care worker's role as the key role, since he is the person who is closest to the child and has the greatest opportunity for potential influence on him.

Having asked the question: "Training for what?", we must immediately ask another question: "Who shall be responsible for the training?" Again, we must report that in many settings, the choice of supervisor is more a reflection of professional needs than it is of the training needs of the child care worker.

Consider, for example, the plight of the beginning child care worker who really needs to know a great deal about how children function in a 24-hour-a-day setting, but who ends up being supervised by a social worker, psychiatrist, or clinical psychologist whose only contact with the child may be in the context of the 50-minute therapy hour, within the sanctuary of his office. One obvious way of avoiding this problem is to use senior child care workers as supervisors. The senior, more experienced worker possesses just the kinds of information that the novice child care

simple behavior management techniques and some suggestions about things to do with children for fun. Later on, as the new worker becomes more proficient and secure in his role, he may seek added explanations from other professionals as to "why" a child acts in a particular way, or what the family dynamics are in a given case. Ideally, the institution should provide for different levels of training, ranging from direct line staff supervision, through informal meetings with agency professionals, up to and including participation by line staff in case conferences.

Whoever undertakes the supervisory task, a certain number of pitfalls are evident and should be avoided. It should be the responsibility of the supervisor to define for the child care worker what will be the basis for their supervisory relationship. This could vary from an intense involvement in what amounts to personal psychotherapy, to a problem solving, teaching centered relationship. It is imperative that whichever format is used, the child care worker be made aware of it. To do otherwise, is to be faced with the situation of some child care workers who entered supervision expecting some sort of insight producing psychotherapy, feeling cheated when they do not receive it and of other child care workers who feel they are being unduly "caseworked", when all they really wanted were some concrete suggestions for how to manage a child's behavior.

In what is often a painful moment of truth, the child care worker sees that it is not easy for his supervisor to calm a writhing child in the throes of a temper tantrum. . . .

worker needs to know in order to carry out his duties within the institution. These include such things as: a knowledge of the rules and routines of the institutions, some knowledge of the individual children, some

Life-Space Supervision

In this form of supervision, the professional moves through the life-space of the ward, or cottage offering assistance and support to the child care worker as he is invited to do so. In this way, he is given an opportunity to model a desired way of managing a child's behavior, rather than just talk

about it in "office supervision". Care should be taken, of course, to move in on a situation only when signalled by a child care worker. The method of life-space supervision is not without its hazards, particularly for the professional. Once outside the sanctity of his office and the protection of the 50-minute therapy hour, the therapist's halo becomes slightly tarnished and his fallibility and mortality become plainly visible to all. In the life-space of the institution, the children act as the "great levelers". They are singularly unimpressed with Ph.D.'s and A.C.S.W.'s and couldn't care less how well versed one is in psychological jargon. In what is often a painful moment of truth, the child care worker sees that it is not easy for his supervisor to calm a writhing child in the throes of a temper tantrum, stop a fight, put an end to a scapegoating session, or convince a timid child that it is alright to join an activity. The child care worker will see his supervisor: make mistakes with children, get angry, say the wrong thing, have nothing to say, and, literally, fall flat on his A.C.S.W. when trying to help restrain a wildly angry adolescent. In short, the child care worker will see the supervisor experiencing all those things which he himself finds so frustrating.

Given the fact that a supervisor has a strong enough ego to operate sometimes in the "fishbowl" of the milieu, the type of training that the child care worker receives will in the long run be most beneficial and lasting. It drives home the message to both supervisor and child care worker that there is no easy way of dealing with all of the problems which disturbed children create in an institutional setting. It tends to narrow the gap which child care workers so often feel between themselves and their supervisors and above all it sensitizes both supervisor and child care worker to the spe-

cial problems which each faces in working with the children and creates a climate which makes working together more than just a nice sounding phrase.

Staff Training for All

It is entirely possible that an administrator could set up an excellent child care training program and still be missing a significant amount of interaction between children and adults, if he concentrates his efforts only on those people who work directly with the children. For those of us whose business it is to relate to children, it is sometimes difficult to admit that certain children will prefer the company of the cook, or maintenance man to our own. Unless we make some attempt to include this group in our staff training, we essentially lose all control over what happens in these encounters. Polsky¹ and others have pointed out the potential dangers in an institution which rigidly separates its professional and child care staff from its house-keeping and maintenance staff. Often the special techniques needed to work with emotionally disturbed children are a source of bewilderment to untrained maintenance and kitchen staff who raised their own children under the maxim: "Spare the rod and spoil the child". For this reason alone, they should be included in some part of the agency's training program.

Group Supervision

It is important to make clear from the outset the nature and purposes of the group. For example, will the leader assume a directive teaching role, or will he take a more laissez-faire stance? Will staff be urged to bring up criticism of each other's work, or will this be left for individual supervisory sessions? Will the group focus

mainly on the children, or on staff relationships?

Another point centers around group decision issues; here, the leader should make clear to the members of the group that there are different phases of decision making in groups: 1. A phase of *Orientation* in which the members acquaint themselves with the various facets of the problem; 2. A phase of *Evaluation* in which the various alternatives for action are discussed and compared; 3. And finally, a phase of *Control* in which the members decide upon an action strategy and take steps to implement it.²

Problems often occur in staff groups when child care workers try to arrive at a "quick fix" solution, without first becoming knowledgeable about all aspects of the problem and all of the avenues open for action. Child care workers eager for concrete suggestions may come away grumbling that, "All we ever do is talk about problems, we never decide anything". It should be pointed out by the group leader that a very fruitful session can be held in which the staff simply tries to find out exactly what is happening, without settling upon any immediate solutions about "what to do".

On a related point, it is essential to make clear to staff groups exactly how much decision making power they have and in what areas they may exercise it. To do less than this is to invite ill feeling and create barriers between the administrator and his staff. It is the author's personal feeling that while the child care staff should participate in decision-making, a children's institution cannot be run on the model of a participatory democracy. Some decisions must be reserved for the clinical, or executive director and these should be made clear from the beginning. Typically, they would include ultimate decisions on intake

and discharge of children, the hiring and firing of staff and matters of major policy change.

Conclusion

One of the paradoxes in the question of child care training is that the problem seems to be less with the people we would like to train and more with ourselves who would do the training. It is with the administrator who thinks that staff training consists of subscribing to a few professional journals and having a few child care workers sit in and listen to a case conference now and then. It is with the therapist who sees no room in his narrow conception of the treatment model for child care workers to be anything more than custodians. It is with the case worker whose only venture outside of his office is to refill his coffee cup, because to do otherwise would be outside of his "professional role". Indeed, the problem is with any of us—regardless of our professional orientation—who refuse to accept the fact that the single most important and influential person in the institution is the child care worker. If we truly participate in helping him to work with the child for all of the other 23 hours—making available our expertise, while drawing on his vast practical knowledge and skill—then "training" in the formal sense of the word becomes less of a problem and we will be well on the road to developing a truly therapeutic milieu.

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David Coogan, M.S.

Henry K. Kaplan, Ph.D.

Moving the Hard to Move

The authors discuss a program for adolescents who are on their way to becoming chronic patients. They found that the youngsters responded favorably to a combination of constant direction and pressure with activities designed to foster a sense of independence.

How does one go about developing a program for that very hard to place adolescent group—the inadequate, intellectually limited, academically retarded, sometimes psychotic teenagers, who become hospitalized for a variety of reasons but whose reason for staying in the hospital boils down as much to fear of the world outside as it does to the community's difficulty in finding a place for them?

This article describes our program for the "non-academic adolescent", touching on both our successes and failures and spelling out what we feel can be done to overcome or circumvent the fear and threat of independent living that is experienced by our patients.

At Mendota State Hospital we have had a school program since 1962 which has been able to more and more adequately educate a broad spectrum of our high school level patients. For the above defined group we "watered down" our curriculum and added some special features, such as budgeting and filling out job application forms, which

we felt could be useful. This was carried on in the classroom and we still had some flickering hope that eventually these youngsters might yet obtain a high school diploma which would in some way open the door to expanded job opportunities. But follow-up investigations of those discharged and the difficulty we faced in working out discharge plans led us to look for educational and training approaches that would focus minimally, if at all, on the classroom setting.

Experience with job placement for three boys drove home to us the nature and intensity of their dedication to spending the foreseeable future in their hospital home. Two of the boys didn't even pay lip service to a desire to leave the hospital. Obviously more was needed and this would have to take place sooner after entry into the hospital.

In the fall of 1968 the senior author took the "teacher, work-coach" role on a full-time basis. He was joined by another full-time coach. We selected ten boys and seven girls as candidates for a long-term effort at fostering both social competence

The authors are with Mendota State Hospital, 301 Troy Drive, Madison, Wisconsin 53704.

and a feeling of being an independent responsible individual. These 16 to 18 year olds had been hospitalized for as long as seven years. Their median stay was 23 months in contrast to the approximate six month stay of our average patient. They were severely retarded academically and their mean IQ was 79. They looked at life as simply random forces acting upon them. There was no rational plan in the world they perceived, and events in their lives were seen as being in no way a consequence of their own actions. Fate or powerful others were seen as the determiners of their existence.

Program Design

The program that was designed presented four related kinds of activities.

1. Practice in independent functioning and social competency

Our first emphasis was on group discussion and "activity meetings". This included group planning for social activities, engagement in the activity both in the hospital and the community, and discussion meetings aimed at fostering insight into self defeating behaviors. The meeting also provided the opportunity for verbally rein-

obtain. Activities have included preparation of food, grooming, and other specific vocationally related activities such as handling laundry.

3. Community-based work habit training

Within a short time we came to realize that our socialization efforts through discussion groups (noted under 1 above) were not productive. The group could not independently generate goal-directed discussions and, as the teacher-counselors entered in more actively, the patients would "parrot" them. Our hopes for meaningful encounter and growth through discussion were shattered, but we did come to recognize the extent to which the patients were ready to endow us with God-like qualities. To some extent, we have attempted to capitalize on this. It was after this failure that our role began evolving from that of counselor to coach.

We adopted the role of coach to encourage team-work and peer-group reinforcement for masculine performance. Looking at our present mode of operation, group cohesiveness is built by the use of "ordeals", i.e. long hikes, rock climbing, overnight camping, and "getting lost" (leaving the boys to their own devices after disorienting them in the woods).

They looked at life as simply random forces acting upon them.

forcing appropriate behavior shown during an activity. We soon moved toward individual "social-task-assignments" e.g. a bus ride alone into town and other more specifically defined activities.

2. In-hospital training center

This was aimed primarily at the girls and included improving skills such as manual dexterity and speed as these might come into play in work they might eventually

During this period we attempt to break dependency on adults by forcing the group to work together. But the coaches remain involved in the sense of providing desirable role models. Strenuous farm work, improving camp trails, tearing down buildings, and, finally, group work in a canning factory have provided a progression through more and more demanding and realistic job demands.

4. *Individual on-the-job training*

This has become the final phase of our program, final in the sense that when our adolescents reach this point they are working for and paid by a private employer. This does not imply that our patients must pass through each phase in order to reach this level. What we have added at this

If the supervisor knows he is dealing with a mental patient he may make too many allowances, using kid gloves, only to have to discharge the patient after a short period of employment.

phase is our own involvement, at the patient's side, as trainer. Employers have permitted us to, in this way, help the patient organize the task, e.g. restaurant dishwashing or factory work, and to develop proficiency. Our role as trainer, which we feel is crucial, if not completely innovative, enables us to handle that patient in the manner that we have found to be most effective. We have found that the regular work supervisor initially feels uncertain about the best way of communicating with the employee. If the supervisor knows he is dealing with a mental patient he may make too many allowances, using kid gloves, only to have to discharge the patient after a short period of employment.

Within the past three months the majority of our boys have arrived at this level. First they worked together in a canning factory under the direct supervision of our coach, and at the time of this writing five boys are working in a variety of community jobs under varying amounts of direct supervision from us. With the exception of two boys who are rooming alone separately in the community, our privately employed working group continues to live in the hospital. This is due partly to their ages and also to the lack of compatible living quarters. We see our girls' group as approach-

ing the point where they too can move into community employment.

This chronological and perhaps too neat description of where we are in our efforts is not presented as evidence that we have arrived at the formula for success. There is a tenuousness in the work adjustment of four of the five boys now working privately and we are well aware of the remaining difficulties in overall social functioning. But we do feel that: 1. We have culled out a number of practices and have gained some confidence in others; 2. If we can pick up our clients quickly, within several weeks after hospital admission, we can combat the iatrogenic effects accompanying institutionalization.

Dealing with Chronic Adolescent Patients

As we have learned what techniques were unproductive we have also found a number of approaches that have been effective. Following are several assumptions under which we operate and the approaches we use to implement our aims.

1. The unconditional imperative

Our patients are dependent both on the hospital and upon others for leadership. Their dependency and fear regarding independence may well be of greater magnitude than any positive pull exerted by conventional reinforcers. Likewise, conventional punishments, such as isolation in one's room, or deprivations may be quite tolerable to them if the alternative is a step toward independence.

To deal with this massive resistance we make our requests brief and specific and in the form of an "unconditional imperative". We attempt to overwhelm any attempt to resist by shouting down protests and demanding that an action be performed because "That's the way it is in this group". All complaints, individual wishes, or de-

mands for explanation of why something must be done are passed off as being irrelevant. We refuse to respond to the endless variety of tactics patients have developed to avoid performing independently. We are often amazed at the demanding yet intrinsically purposeless activities they will carry out without resistance once the "imperative" ethic permeates the group. Trudging through swamps or climbing steep hills are examples of such ordeals.

The use of the ordeal, noted above, aids in the development and acceptance of the "unconditional imperative". We have found that this can be inculcated into the group so that the members themselves come to exert a kind of control over a recalcitrant. Thus, if one member complains about illness, for example, the others spontaneously laugh as if to indicate that such a statement is incomprehensible if not unthinkable. The group, when responding in this fashion, is more effective than the coach can be. The purpose of the unconditional imperative is to convince the patient that there is no alternative available to carrying out the proposed assignment, and, in a sense, we keep him off balance in our effort to accomplish this.

Refusing to even hear complaints and constant shifting of attention to positive aspects of a job seem to have good results. The patient at times becomes so confused by the torrent of praise and push that he forgets his complaint and charges back to the job with new enthusiasm.

No attempt is made to be logical or to permit the patient a choice about returning to work. We have become convinced that many of the patients never hear nor understand the content of what is being explained to them. What is said isn't as important as the emotional tone used to communicate it. It is most important here to talk encouragingly, in good humor, and fast, all

the while pushing the patient back to work. Suggestion, then, is in a sense a step beyond the cruder unconditional imperative. In this the coach can maintain a pleasant manner.

2. Suggestion

Many of the patients in the group seem especially susceptible to suggestion. Good performance can often be maintained by periodically telling the patient how much he, the patient, likes what he is doing. Short pep talks take the place of discussions.

3. Regular and close communication with employers

We feel that weekly checking with employers on a patient's work is, by itself, ineffective. The work supervisor must be encouraged to convey freely what is actually happening on the job, and this has a better chance of taking place if the coach has already indicated that he is intimately familiar with all of the client's tactics. The work supervisor must obtain a grasp of the coach's goal so that he neither coddles the "mental patient" only to discharge him at the end of the week, nor rejects him outright.

The opportunity, where possible, for the coach to work with and directly supervise the patient for at least a brief period is extremely useful. Knowing the patient's work shortcomings, he can break down the units of the job to segments meaningful to the patient while still carrying the unconditional imperative to the work setting.

Some Necessary Conditions for Moving the Hard to Move

We have been fortunate in having the interest and cooperation of several indispensable resources in dealing with this very resistant group.

First, we have found a number of employers in the community who are willing

not only to give our patients a chance but also to permit us to spend time right at the work station with the patient. We have been successful in developing a relationship with several employers to the point where we can communicate our goals and look to them to follow through.

The vocational rehabilitation counselor has made his resources available mainly in the form of funds for emergency living expenses and paying patients for community-based jobs such as the forestry work noted above. The counselor has also at times aided in the coaching, familiarizing himself with the jobs and doing the training at the work station.

In the above techniques we are admittedly bending the client to our will. There is questionable personal growth at the moment of his acquiescing, but he is accomplishing the task demanded and we see this as being of paramount importance. And there is a paradoxical situation inherent in this; with some success in a job the client loses some of his dependence and in turn becomes less easy to manipulate. Thus, the time should come when the client begins to view himself as having some competence for self determination, and he might then realize that he needn't permit himself to be "conned" into working. We have found that at that point the more common types of reinforcements can be brought into play.

Good performance can often be maintained by telling the patient how much he, the patient, likes what he is doing.

Community agencies such as Goodwill Industries have likewise permitted us to temporarily become part of their supervisory team. We have found that with patients with relatively good occupational potential the workshop assignment should be rather brief. As with stay in the hospital we feel a strong need to convey to patients

the idea that their assignment is time limited, that they will soon move out to private employment.

We feel we have been successful in orienting ward personnel to our goals and they have been willing to follow through with our approaches. In many cases they had been witness to the failure of traditional educational, treatment, and job placement efforts and have been as enthusiastic as we have been.

Conclusions

We have described our approaches with a group of teenagers for whom the prognosis at best is guarded. In most cases their families have been non-existent or have not been a useful resource, and these patients have experienced little but failure prior to entering the hospital. Our hope has been to find ways to avoid protracted hospitalization and to nudge our patients into at least a marginal kind of existence in the community. At this date 22 young people have been included in the program. The five working in the community at this time are boys. The girls are considerably younger and therefore most of them are not able to be placed yet. The fact that our coaches are male and that much of our activity is male oriented is probably also a factor in this.

We have yet to face the question of the duration of our contact with the patients after they leave the hospital, though we know that some kind of follow-up services are necessary. We can look to difficulties in social relations and in managing many facets of their personal lives. But at this point we feel some gratification with our ability to bring some feeling of accomplishment into their lives. Finally, as we continue, we are seeking to identify our candidates very early in their hospital stay and to begin our program before their fears of life in the community grow beyond reason.

Samuel Tenenbaum, Ph.D.

School Grades and Group Therapy

Nine students who were on academic probation attended group therapy sessions once a week during one semester. Their grades improved dramatically.

There are no lazy people. There are frightened people, anxious people, bored people who have found no meaning in life and hence no meaning in the activities necessary for life. And there are people who have unrealistic notions of who they are and what they are. They, too, are crippled for realistic living. As for students, what keeps them from their work for the most part is fear of failure, terrible self-demands, low self esteem, inability—intellectually or emotionally—to cope with the tasks set before them. In our culture, students find it more acceptable and more respectable to plead disinterest and laziness, rather than lack of capacity and intelligence, and this is the way most students and parents prefer to explain failure.

In the main, young people who have school problems are immobilized by their fears. When a child is doing poorly at school, teachers are wont to attribute it to indolence and laziness; rarely to his fears, his hang ups or his great desire to please his parents, all of which may be debilitating and self-defeating.

There were a number of education major students at Long Island University who

had been on probation semester after semester. Before expelling them, the then Dean of the Division of Education, and the adviser of the Educational Counseling Service thought that as a last chance, they ought to be given the opportunity of having a group therapy experience. I was asked if I would like to take over the group and I accepted, having advocated such group experiences, not only for students in academic difficulties, but for all our students for many years.

About 15 students were originally assigned to the group. Six came once or twice and never came back. I was left with a group of nine, six of whom came regularly and three irregularly.

In my private practice I seldom experience a cancellation. The thought that students who did not pay a fee would reject the chance for a therapeutic experience was something I could not contemplate without of severe blow to my self-esteem. But this was my own problem and I never communicated this to the group. I held firmly to the belief (and I still do) that it was for each student to decide whether he wanted to attend or not; and if a member stayed away, I interpreted it to mean that he wasn't profiting and it was, then, a reflection on me and not on him. Every absence made me feel very uneasy and guilty.

Dr. Tenenbaum is a Professor of Counseling and Guidance at Long Island University. Requests for reprints may be addressed to him at 222 West 83rd St., New York, N.Y. 10024.

From the outset I never asked students to work or study harder, for I assumed that the thought had occurred to them; or if not, someone else had told them of the need. Never once did I bring up the matter of grades unless they did. I did try to listen, to be sensitive to them as they expressed their grief, worry and often despair. As I listened I often wished that faculty members could be present and hear these anguished communications, so that they could understand what a grade means.

Although students could attend at most ten sessions of one hour and a quarter, not one of the nine failed a single course, not only during the semester in which they participated in the group experience but also in the semester that followed. Where hitherto their records had been filled with Fs, Ds and Cs, after their group experience there were several As, B+s, Bs and C+s.

Prior to their group experience, grades C+ and higher for these students came to 24.7%; after the group experience it rose sharply to 65.0%. Before the group experience, grade C and below came to 76.3%; after, it was 34.5%. In all their previous school experience, these students had failed 10.4% of their courses. After their group experience, they did not experience a single failure or F grade for the entire academic year. As for the D grade, there was a sharp drop, from 31.2% to 9.6%. Even for the gentlemanly pass, the C grade, there was also a drop from 28.9% before to 22.5% after. These percentage deficits in C and lower grades were made up by the sharply upward movement to grades above C after the students became involved with the group.

In their prior years at Long Island, (two had attended the university six semesters and seven, four semesters), these students made altogether one A, which was 0.5% of all their grades. In the semester concurrent with and the semester following

their group experience, they made eight As, representing 8.6% of all their grades. Before their group experience, their B+ grades came to 2.3%, after, 10.6%; their B grades before, 9.8%, after, 25.8%; C+ 10.4% before, after 17.1%. After the group experience, their grades rose markedly from the lower end to the higher end of the grading scale.

During the semester of the group meetings, I asked the students to write brief reactions to each session and several of those are quoted here.

At the start, they found talking difficult; and their communication was random and

Although they were doing unsatisfactory school work, it appears that every member of the group had the requisite intelligence to perform the academic tasks set before them.

desultory. They could not understand how plain, ordinary talk could help them with their grades. All were reluctant to reveal their probationary status and their silences were long and severe.

These are two typical early reactions:

I noticed today that we, as a group, have a lot in common as to why we are on probation, but that our fears of being with strangers prevent our really coming out with the true facts of our problem. . . . I am sure if someone starts, others will follow.

I don't see how anyone can really be helped. . . . and there are many things I won't say because there are other people in the room.

One member took to the process immediately:

After leaving the first session I felt as if a great burden was lifted from my shoulders

"One thing we have in common is meddling parents."

because for the first time in my life I could speak freely of the personal problems which I have been faced with in the last few years. . . . For the first time in a long while I didn't feel any anxiety about being in a classroom.

Mostly, however, they did not know how to articulate feelings; and they resented having to make the effort. This was a hard stage for them and for me. Wrote one member: *"If it seems that I don't participate as much as the others, it's just that I get very upset telling my problems. . . . I hope at future meetings it won't bother me as much to tell my problems."*

Gradually, they talked less and less about school and grades and sought each other out for support and comfort. Bound as they were by a common grief—the pain and the hurt and the shame of their probationary status—the group slowly began to jell and assume a close, in-group quality.

I was happy during this session because I felt that we are learning different facets of each other's personalities. I felt in the past our lives started and ended with classes and that we had no other lives outside of school. During the hour we spoke of ourselves socially.

It is amazing to what extent parents figure as a disturbing influence to the members of the group; how, instead of helping them, they fill them with disturbing emotions, so that the tasks in connection with school do not become a personal student involvement but a way to win parental approval and an honorable and respected position in the family. For these students, school represents nothing but a vehicle to get grades sufficiently high so that parents

will think well of them. For the openly rebellious, a struggle may develop between student and parents. The parents will badger their offspring: "Have you studied enough?" "What grades did you get on your examination?" "Have you done your homework?" The educational experience becomes subsidiary to parental needs and demands. In such instances, there may be acrimony and bitterness and sometimes despair, not because of what goes on at school and what school represents, but at what goes on at home. Here are typical student reactions:

I was very glad to see that I'm not the only one with "mother problems."

One thing we have in common is meddling parents. I am not saying this is the cause of our probation status, but it may very well be one of the causes.

The parents took the responsibility of the school task away from their children. Further, no matter how they rebelled and how bitter the acrimony, these students took it for granted that their parents were right and that they were worthless. Although this did not make them better able to cope with the school situation, it did make them feel guilty and inadequate. These feelings, in my judgment, only accentuated students' anxieties and made them less able to meet school demands. In the group sessions, students began to perceive how parents figured in the school situation, and to understand better the nature of their parental relationships. One student writes:

I realize that my mother will never be pleased. That is something I never realized. I'm sure this . . . will help me . . .

now and in the future. For if I keep listening to her, I may find I'm living for her rather than for me.

Although the matter of grades and probation was always present, the discussions soon went far afield of grades. They included their whole persons; how they struggled, how they failed, also, how they triumphed. In my opinion, this proved to be the most valuable part of the experience since it helped them gain realistic insights into their own difficulties and their own persons.

I feel that much was accomplished in (our last session) in that the meeting really brought me to thinking why I got marks as I did . . . The family situations described (by others) were somewhat like my own so I was helped in that area as well. . . . Though I don't fully understand why I've been so erratic in my work, I know that it has been at least 90% of my own doing and I aim to better myself.

In the final stage, they were a united group, working in unison, understanding one another, better aware of their own feelings and their own problems, more realistic about what needed to be done. Below is one reaction articulating this new awareness of self, these new insights and new resolutions.

I truly believe that our open-mindedness about our individual problems has helped us to achieve our success. If we can continue to verbalize about ourselves, then surely we can allay our fears about school. . . . Of course, we have to work and study, but I feel that by talking, half the battle to get off and stay off probation is won.

I asked for a final reaction as to how they viewed their experience and requested

that they send me their final grades. These were mailed to me after their final examinations and long after the group had broken up. I wish there was sufficient space to quote these communications verbatim.

One in particular sums up the many reactions:

. . . it was a very good feeling to know that there were others in the same category as myself; and that there was a person, such as yourself, who seemed to take an honest interest in each individual. I feel that now that I am off probation, I will stay off.

Discussion

At first the group members did not know how to talk and were reluctant to talk. Each member of the group thought that "being on probation" was unique to him and each carried this burden for the most part secretly and in shame. When they discovered that all in the group were on probation, it had an exciting, liberating effect. Eventually, their common problem served as a bond and a tie to unite them.

I want to emphasize that in none of the sessions did I bring up the matter of their grades; in no instance did I make them feel that I wanted them to get higher grades, or that I was in any way involved with their grades.

Although the group members' probationary status was always present, once they revealed themselves as persons, they discussed grades from a deeper and more significant point of view. Grades became linked with their anxieties, their hopes, their weaknesses, their failures, their parents, etc., etc.

In the group, the members received regard, encouragement, support, affection. Their ego strength increased, their self-respect rose, and as one of the outcomes,

I believe, they were able to confront their school situation in a healthier and more intelligent way. They were able to view themselves and their problems more insightfully, more realistically. One spoke of anxieties so great that she could scarcely live through an examination. Others spoke of frightening instructors who marked you down for anything and everything so one couldn't think. My heart went out to these unfortunates, as they tried so hard to make themselves small and inconspicuous in class, fearful of being called on. Others spoke of personal situations which they faced that kept them so distraught that they were immobilized from doing anything. "I got started studying and then my mother got after me and we had the worst fight in a month and I couldn't study, and she said I was no good and I would never be good." The tears rolled down her eyes. "I couldn't study . . . and I couldn't sleep that night."

The group experience made the members more articulate. Before they were silent in class—outsiders. As they became more aware of their feelings and better able to articulate them, several managed to develop more personal relationships with some of their instructors and, best of all, a number became more active as class participants. These began to feel like persons and act as persons, not nonentities.

When I discovered that the group members made even higher grades in the following semester than they did while they were undergoing the group experience, I was puzzled until the thought occurred to me that they did not have the full force of whatever is therapeutic in a group until the following semester; and that this could account for the difference.

Although they were doing unsatisfactory

school work, it appears that every member of the group had the requisite intelligence to perform the academic tasks set before them. In fact, several became, after the group experience, not only successfully functioning students but superior students. The question arises: On what exactly does academic success and failure hinge? Are grades a symptom of the whole functioning person, who and what he is, and not primarily a matter of intelligence which hitherto was regarded as the main and only component? If yes, what are these other factors? Further, if these students had not undergone the group experience, what would have happened to them? How would their lives have been changed? This is a matter not to be taken lightly. In our society, college graduation is the union card for valuable rights and prerogatives, vocational, social and even marital. Would they have ruined themselves on their own or would they have been expelled as academic failures with all its inherent emotional and psychological trauma, very often lifelong.

This is not a statistical study. It is rather an account of nine persons, each one apart and separate, who participated in a group experience. Although we can conjecture, I do not believe that at this stage we know exactly what happens to the members in a group of this kind, how a group affects each in it, and how each in it affects the group.

The hope is that with time, with further study and inquiry, the process will be better understood and therefore better controlled, and hence, we will be more able to replicate outcomes. Even with our present knowledge, we have every reason to believe that when a group works, it can be highly salutary and therapeutic, in ways which we have not nearly plumbed.

Alfred M. Wellner, Ph.D.

Lewis M. Garmize, Ph.D.

Gregory Helweg, M.A.

Program Evaluation: A Proposed Model for Mental Health Services

The authors propose a model of evaluation that will help mental health program planners and directors to conceptualize the issues and components of a program evaluation system. It includes three levels—Outcome Effectiveness, Strategy and Systems Overload—that can be examined to provide a clear picture of the service.

This paper is an attempt to provide a basic model for the systematic collection of relevant information to permit personnel to evaluate their programs and to, thereby, modify the programs to achieve maximum output from available resources. There is a need for an evaluation model that serves to stimulate the application of evaluative procedures for mental health services and function as a general guide to concepts in evaluation for personnel with relatively limited experience in this area. Goals in the field of mental health have been primarily "non-operational" in the sense used by March and Simon¹. That is, the means of testing action have

not been perceived to be related to a particular goal or criterion with possible alternative courses of action.

There have been recently, a number of reports and papers on program evaluation in mental health.^{1, 2, 3, 4} Suchman's⁵ text is an excellent work on the principles underlying evaluative research in service and social action programs. The survey of a selected group of community mental health centers, however, indicates that little or no evaluation was being conducted at that time.² Few of these reports have given systematic attention to the planning strategies and dimensions of choice which structure the complexity of the evaluative process.

Dr. Wellner is Chief of Psychology Programs, Maryland Department of Mental Hygiene, 301 W. Preston St., Baltimore, Md. 21201. Dr. Garmize is Consultant in Psychology, Maryland Department of Mental Hygiene and Mr. Helweg is a psychology doctoral candidate at the University of Maryland and a Career Trainee with the State Department of Mental Hygiene.

The Model

This proposed model for program evaluation is based on the premise that all programs can be systematically reviewed for

the purposes of: a) determining the characteristics of services provided or the process of service delivery; and b) the degree to which the stated objectives of the service are being met. The model also assumes that these are two separate and distinct evaluative processes. The model also supports the principle that evaluation should provide information on why a program did not meet a stated objective or goal, and not just whether it did or not.⁹

In addition, this evaluation model recognizes the need to systematically identify service and administrative demands which are not being met. That is, it seems essential to also identify actual demands as well as theoretical needs of the facility and its personnel.

Level I—Outcome Effectiveness

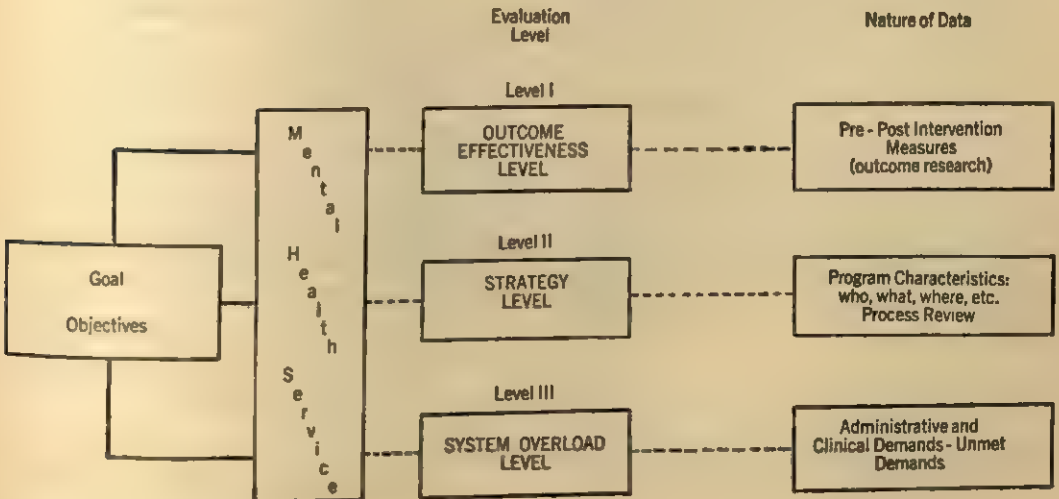
This level of evaluation tests the assumption that intervention changes the

consumer or target population in the directions specified. The question answered by the level is, "Has the program been effective in attaining the goals specified?"

These goals must be precise and measurable. The intervention may be considered as "treatment" or "services." In order to clearly establish the relationship between the intervention and the goal, pre-intervention measures are necessary. Post-intervention measures are also necessary if careful and meaningful comparisons are to be made. In addition, pre- and post intervention measures must be taken on potential consumers of service who do not receive the intervening treatment (a control group).

Changes in desired directions on post intervention measures, if they occur, are not sufficient tests of effectiveness. It is possible that these same changes could result from just the passage of time. It is therefore necessary to include comparisons with groups receiving no intervention.

THREE LEVEL EVALUATION MODEL



The basic effectiveness evaluation level includes the following essential elements:

- a. identification of precise and measurable goals
- b. selection of potential consumers (target groups)
- c. obtainment of pre-intervention measures
- d. application of intervention to part of potential consumer group
- e. obtainment of post-intervention measures
- f. comparison of results:
 1. pre- and post comparison
 2. intervention and non intervention comparison

Further refinements, yielding more precise information, may be introduced. For example, rather than simply obtaining pre- and post intervention measures, one could obtain measures at various stages of intervention (e.g. 2nd, 10th, 16th session) and again at the termination of the intervention and at intervals thereafter (e.g. 6 mos., 1 yr., 5 yrs.). These refinements require considerable effort and manpower committed to evaluation or programs. The instrument selected for measurement will depend on the goals specified and can include behavior measures, rating scales, interview data, etc.

Evaluation at this level normally requires considerable research input not normally provided by on-going programs. It is essential, we feel, for program directors and other personnel to be aware of the special research need of attempting to deal with the issue of program Outcome Effectiveness.

Level II—Strategy

In this evaluation level, information is obtained regarding the nature of services

provided. Basically, it answers the question of who is doing what to whom, when and where.⁴ Information derived from this level gives a clear analysis of how staff is using its time and the characteristics and process of the services provided.

Most programs routinely collect information on the characteristics of services provided. Budget requests are usually accompanied by data which reflect some aspects of services rendered and the nature of the personnel who are providing the services. The following outline provides for the identification of Level II components and for facilitating analyses and comparisons of the major groupings. The specifics under each grouping will have to be determined by the nature of the program. It would be very difficult if not impossible to try to identify each and every possible category under each heading. (For example, under the "who" component we have listed community agent as a sub group.) There are too many different kinds of community agents (police, welfare workers, ministers, etc.) for a complete listing. Each program can identify the groupings appropriate to its services.

Definition of Components

- A. Who—Who is providing the Service?
Description of training and experience of staff providing service.
- B. What—What is the nature of the problem and service function? Description of service provided in relation to problem presented.
 - a. Target Problem
What is nature of problem presented? (Medical, Behavioral, Social or Educational)
 - b. Function
What is nature of the service provided?

- C. To Whom—Who is the recipient of the service? What is the target or consumer group?
- D. When—What time period is the service provided? What time of day or what time of stress or when in consumer's life experience is service provided?
- E. Where—Where is the service provided?
 1. A mental health facility (hospital, clinic)
 2. An existing community agency (welfare, church, etc.)
 3. Turf*—where the crisis or problem occurs (e.g. home job, location, street, etc.)

As can clearly be seen, information gathered at this level will give a good overview of the nature of services provided, the delivery of those services, and their extent. It will also delineate the professional functions and the target problems with which the program is dealing.

Describing functions according to the Strategy Level gives a clear account of the options exercised in the program. These data provide a view of the community served, alternatives or additions of manpower utilization, of service rendered, the target problems.

Data included in Strategy Level evaluations do not necessarily bear on the effectiveness of the program. These data do identify specific interventions, however, and in so doing they may identify the steps in Outcome Effectiveness evaluation. Strategy level data do not in themselves justify the program.

Systems Level III—Systems Overload

In this level of evaluation, the issues regarding the demands on the services, both administrative and clinical, are identified. It is essential to maintain on-going records if the services staff is unable to provide them because of personnel or budgetary limitations. Backlog of dictation, unmet speaking engagements, waiting lists for clinic services, staff inability to accept invitations to join local committees, etc., all reflect an overload of the system and should be identified. This level data reflect what could be done if additional services were available or a different utilization of services were designed.

This level of evaluation, like the Strategy Level, is one which is often associated with budgetary request justifications. It provides data on which many programs expand in response to demand—sometimes (too often) without the benefit of an Outcome Effectiveness study. That is, demands create overloads on the system which responds by expanding itself. It may be that if the system were evaluated and possibly re-structured without additions, the demand could be met more effectively and efficiently. The development and expansion of the state hospital system is a good example of the potential problems of expansion to meet "demands" without systematic analyses.

In a program which has been evaluated at the Outcome Effectiveness level and found to be effective in meeting program objectives, such System Overload data is particularly helpful in support of expansion requests. In those programs where no such evaluation has been accomplished, Systems Overload data do not necessarily support requests for expansion.

Programs in the field of mental health have very rarely been evaluated at any of

* Term suggested by Gregory Helweg.

the above three levels. Research studies in the literature are primarily of the Effectiveness Levels of very specific intervening activities. The statistics that are usually collected in mental health services regarding number of patients seen, (Psychiatric Case Register, for example) type of treatment provided, are primarily of the Strategy Level and are usually quite restrictive in terms of content. Very rarely does this information lead a program director to alter his program or to be able to refine or redefine it. The Systems Overload Level is the one with which administrative personnel have been primarily concerned for budget requests, without, however, the accompanying Outcome Effectiveness level data.

Summary

This model is proposed to assist program planners and directors in the field of mental health to conceptualize the issues and components of a program evaluation system. The Strategy Level can be used by program developers to assure the inclusion of all components of a delivery system. It can also be used as a preliminary guide to the kinds of data that should be collected in order to have base-line information on the nature of services.

The combination of the three evaluation levels provides a concise and yet complete picture of the services, their problems, and their characteristics. It should be pointed out that programs which attempt to use an Outcome Effectiveness Level evaluation model, will require individuals assigned to data collection, and research efforts. To realistically answer the question of how effective a program has been, measures will have to be taken before and after the introduction of that program. Indeed, it would

be advisable for such Outcome Level evaluations to also include a comparable target group for which no intervention is provided which can be compared with the target group for which the service has been designed. This would provide an even more rigorous comparison and analysis of the effect of the service intervention.

The Systems Overload Level should assist directors of mental health services to become aware of the need to classify and categorize the kinds of demands made upon the services which are not reflected in the usual statistics and patient records.

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Kenneth Z. Altshuler, M.D.

John D. Rainer, M.D.

Observations on psychiatric services for the deaf

Total deafness from birth or early childhood is marked by a severe communication barrier and great difficulty in learning verbal language. These deficits often complicate neurotic or psychotic symptoms which may exist. The authors describe their experiences in working in a comprehensive program of services to the deaf mentally ill. Experience has shown that some individual therapy with group therapy and pharmacotherapy are effective. In addition, consultation, treatment and group meetings with deaf students and their parents serve the purpose of prevention and early detection of emotional difficulty.

Being deaf from birth or early life means that audition is not available as an avenue of communication with the world outside. The most obvious resultant difficulty is the failure to learn verbal language without years of special schooling and arduous, unrelenting effort. So demanding is the task that only about one quarter of those with early total deafness ever develop really usable speech—the majority relying primarily on manual communication, the language of signs and finger spelling. While

there had been several studies attempting to discern and define the psychological sequelae of deafness,^{3, 4, 5} psychiatric interest in this group emerged only in 1955, when New York State established its first Mental Health Project for the Deaf. Over the next 15 years, the program evolved so that it now provides a complete set of psychiatric services.

Early findings and current organization have been reported elsewhere,^{1, 7, 8} and the present paper will focus only on a discussion of the techniques found applicable to work with the deaf, some of the indications for them, and the results achievable when a balanced program is available. By way

Dr. Altshuler is Assistant Clinical Professor and Dr. Rainer is Associate Clinical Professor, Department of Psychiatry, Columbia University, College of Physicians and Surgeons. Both authors are with the Mental Health Services for the Deaf, Dept. of Medical Genetics, New York State Psychiatric Institute, 722 West 168th St., New York, N.Y. 10032 and Rockland State Hospital.

This paper is adapted from one presented to the Institute for Psychologists to Deaf Children at the University of Pittsburgh, May 1968.

of general introduction it should be said that for effective psychiatric work with most deaf patients, a knowledge of manual language is the *sine qua non*.*

Individual therapy continues to be the primary weapon in the psychiatrist's armamentarium. Psychoanalytic work, modified of course to allow for face-to-face communication, has been useful in only an occasional case.

The more widely applicable approach has been a combination of supportive treatment with the achievement of limited insight. Many patients are unsophisticated or have little motivation for the struggle required to make a firm internal change. They approach the doctor on a magic-craving level, hoping he will convert the environment or somehow do away with the problems.⁶ Supportive therapy allows one to make use of this tendency rather than to analyze it. Direct guidance and counsel are the tools, and the parentified relationship with the therapist is the vehicle. This approach is useful with the more psychiatrically disturbed outpatients and with the hospitalized deaf patient, many of whom have severely underdeveloped communication skills. Role playing and instruction in social and job relationships and expectations are often required, as is also the actual teaching of language—especially to hospitalized patients.** Changes in behavior initiated at the therapist's direction will often lead to the patient's becoming more comfortable and thus pave the way for him to begin to see what it was in his previous behavior that had

elicited unpleasant situations. This is the limited insight aimed for, since deaf patients are often strikingly unaware of the impact of their behavior on others.² With the recognition that what they do has an effect on other people a whole new vista of human relationships may be unveiled.

Group therapy has also been adapted for work with our deaf patients. We began such treatment with the first several patients available (females) when the inpatient unit opened in April 1963. After three months with this group of ladies it was apparent that, despite some movement, little was happening. When the first male patients arrived and were included in the group, things perked up noticeably—grooming improved in both sexes, and motivated behavior appeared more clearly: rivalry, sexual interest, and active withdrawal, for example. From this we decided that the groups should have members of both sexes.

Later we tried an experiment in self government, to foster independence and a sense of responsibility. At first patients motivated each other to improve their communication abilities or ward performance, and made recommendations for ward improvements or even with regard to minor self-disciplinary measures. Then a young psychopath bullied his way to the presidency, converted the democracy to a dictatorship, and held kangaroo court on the defiant. We suspended the government and learned that group work with hospitalized deaf patients required firm, though flexible leadership.

As the group experience continued to unfold it was also clear that the patients required consistent encouragement to evaluate each other's statements and their own reactions to one another. It was also noted that, in addition to being deaf and mentally ill, many of the patients were in-

*The staff of New York State's project—aides, nurses, social worker, psychologist and physicians—are conversant in manual language, and weekly, continuing classes have been held since the first project was activated.

**A full-time teacher of the deaf is part of the cadre in New York's inpatient unit.

credibly naïve and ill informed. Long hours were necessarily used for just conveying information or a concept: an employer's expectations on a job, for example, or why honesty or restraint is generally preferable to the self-willed grab. This further emphasized the need for flexible leadership under which the group could be used as a forum for general education as well as more directed psychotherapy.

We also adopted the use of a patient as group leader or co-therapist for one of the three sessions a week that the groups met. This was done in a further attempt to foster leadership, self respect, and reality-oriented critical thinking, and to structure the group toward mutual involvement and away from nagging concrete questions to the therapist about "When do I leave the hospital?" and "When do I get more (hospital) privileges?"

Following these principles, our experience has indicated that group therapy for the psychotic deaf is well suited to serve as a vehicle for broadening general experience and for learning to function in what

meetings with adolescent students are also conducted.

Results of the groups thus far suggest that they are achieving their purposes. Complaints about the school and its programs and regulations have served as a springboard to develop ideas about personal ambitions and responsibilities. In a number of students there has been a notable shift from self-willed rebelliousness to better cooperation, longer range planning, and a sense of themselves as responsible, maturing young adults.

Groups of parents meet as well with the psychiatrist in charge of this part of the program. One group is composed of parents of young deaf children (five to eight years of age) and another of parents of older, adolescent students. The parents of younger children have responded hungrily to the group opportunity. Parents of older children, while evidencing great need for counseling, have been more difficult to involve in the group sessions. Having raised their children to the ages of 16 or

When the first male patients arrived and were included in the group, things perked up noticeably . . .

is a society in microcosm. It has been found to be a valuable adjunct to the individual therapy, medication, social work services and other ancillary programs of treatment available at the unit.

The most recent additions to our program of psychiatric services for the deaf are a preventive effort at a school and a rehabilitation program extending from the hospital into the community. In the school we provide individual consultation and treatment, and discuss the findings with teachers and cottage parents so as to assist the student to function and to succeed, and enable him to mature healthfully. Group

17, they apparently have developed comfortable ways of insulating themselves against their own conflicting feelings. As a result they have a vested interest in seeing themselves as "good" parents, and they tend to blame any difficulties on the school or other social influences while rationalizing their own distorted ideas as being well founded in reality.

A final word about the rehabilitation aspect of the psychiatric program. To help patients bridge the gap from the structured hospital to the community we have developed a working relationship with Fountain House, a halfway house in New York

City. The House program calls for living accommodations in separate, though supervised, apartments and supervised work ranging from office duties to participation in a thrift shop, a car wash, and industrial activities. A number of our patients with-

It is worth emphasizing that at eleven to thirteen dollars per hospital day, each patient-year averted saves the state government at least \$4,000.

out families or roots have been helped into community living through this program. Our tie-in with the Division of Vocational Rehabilitation allows us to open cases and make arrangements early while patients are still on the ward, so that training programs are available soon after discharge and may be continued from a patient's own home base or the halfway house living quarters.

At this moment we cannot predict with any certainty the results of a preventive program. If measurable at all, its tangible effects will only be felt after several years. While evaluation of psychiatric results poses a host of problems generally, a reasonably clear measure is attainable with the inpatient unit and rehabilitation program. Here each patient serves as his own control, and his previous history, coupled with a knowledge of what hospital treatment may usually offer, can allow some basis for prediction. We obtained such an independent prognosis for all patients present in the hospital unit during the first two years that the rehabilitation program was in effect. A psychiatrist with long years of state hospital experience reviewed each patient's record and made his prediction according to the following categories:

Poor—patient will probably remain chronically hospitalized for life.

Guarded—no real improvement expected, may be out of the hospital briefly, but will probably be in the hospital more than out for the balance of his life.

Fair—some improvement expected, probably will be out of the hospital more than in, although exacerbations of illness are expected.

Good—chance of permanent rehabilitation with no or occasional brief returns to the hospital.

After two years of operation we charted the following results. Of the 47 patients expected to remain hospitalized for life, 18 achieved good or fair results. Similarly for 14 of the 16 patients expected to be out of the hospital briefly at best, the results were also good or fair. All with current results of "good" and all but three in the "fair" category have been discharged from the hospital. Of those with original prognoses in the "poor" category, seven are now working, three are in training programs, and three are effective homemakers; the comparable figures for the "guarded" group are five working, one in training, and four homemaking. It is worth emphasizing that at eleven to thirteen dollars per hospital day, each patient-year averted saves the state government at least \$4000. Less tangible but just as gratifying are the personal benefits derived by a person who can leave the hospital to contribute productively to his own support and fulfillment.

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On The Highway

Enemy earth,
Alien earth,
Changing to
Friendly earth.
Flowing with the guard-
Rail lights,
I am in an underwater
Ecstasy of
Light and smoothness.
Flow on,
Drive on,
I may
Come to dry land
Yet,
Touching friendly
Earth,
Solid earth,
Wonderland earth,
And no longer
Needing
The fantastic waterways
Of my dreamings.

—Annie Wu

The Widow as a Caregiver in a Program of Preventive Intervention with Other Widows

"I know what it is like. Let me help you."

The author discusses the use of a self help group in preventive intervention. In this case, a group of widows reach out to recently widowed women and offer support in helping them adjust to their new life.

One of the primary problems programs of prevention face is how to seek out people who have not asked for help. There is the question of who is the appropriate caregiver for such a population?¹ The Laboratory of Community Psychiatry confronted this dilemma when it tried to develop a program that would prevent emotional illness in a population of bereaved people. In this instance the target population with the high risk of developing serious emotional distress consisted of younger widowed people. A caregiving group had to be defined that would be acceptable to them. This paper describes the caregiving group chosen, their special qualifications as interveners, and discusses the kind of intervention they provide.

The caregiving group consists of other

widows who have recovered from their bereavement. It was hypothesized that if another widow reached out to the new widow she would be accepted as a friend because she was someone who understood since she had been there herself.² Does experience bear out this notion that the recovered widow is an appropriate and accepted helper? The material that follows presents data which provide some answers to this question.

The Widow to Widow Program

The Widow to Widow Program, as this demonstration in preventive intervention is known, has been in operation for three years. Five widows have reached out to over 400 new widows under the age of 60 in this time.⁴

The widow caregivers, called aides henceforth to distinguish them from the widow recipients, all live in or near the community

Dr. Silverman is Project Director of the Prevention Intervention Study, Department of Psychiatry, The Laboratory of Community Psychiatry, Harvard Medical School, 58 Fenwood Road, Boston, Mass. 02115.

they serve. They have all been widowed about three years, are for the most part in their mid-forties, and have no more than a high school education. While their husbands were alive, they devoted themselves to raising their children and keeping house. Two of them did help their husbands in his business. After his death they all had to think of supplementing their income, which came largely from social security and pensions.

Each of the aides had become involved in community activities subsequent to their becoming widows. It was through our contact with these community organizations that we were able to recruit them. Until now they had never thought of earning their living helping people in this way. All of them could talk about their bereavement, the very difficult time they had and the current problems being widowed still created for them. They had only one reservation about the program as it was described to them. They wanted to be sure that service, not research, was the main purpose of what they would be doing.

In order to assure that their experience as widows would be utilized to the maximum no attempt has been made to supervise their work. At weekly group meetings people they visit are discussed, and they use each other as well as myself for consultation about what they have done and about how they might proceed. Most frequently they chart an independent course of action which seems right for them and the new widow they have visited.

They quickly corrected our notion that within one year, or less, a widow has recovered from her bereavement. They feel that although by then she *may* be over the acute stage of her grief, she is not recovered, and may even be depressed by her growing awareness of what the loss means. They say a widow never recovers but rather learns to

adjust to the situation. They thought this took about two years to accomplish. It involves an ability to repattern her life without a husband, to find new friends, new interests, and sometimes a new career. It also means learning to live with loneliness.

Initial Reaching Out and Service Offered

How is their experience translated into their work? Their first task is to establish their credentials as an appropriate caregiver; that is, as someone the widow will accept and see as potentially helpful. The new widow first learns that the aide, too, is a widow in the letter of introduction she receives. The stationery has the names of the three religious groups sponsoring the program on it.* In the letter the aide tells the new widow that she will visit at a given time on a given day. She gives her home phone number and invites the widow to call if for any reason she does not want the aide to visit.

They wanted to be sure that service, not research, was the main purpose of what they would be doing.

The aides do not feel that a visit before three weeks would be useful to a new widow. At the moment of acute bereavement they do not feel that a new widow can identify with another widow, because she still thinks of herself as a married woman.

Several things influence the widows' response to this letter. One is their willingness and readiness to consider that they are

* The program is sponsored by the Archdiocesan Council of Catholic Women, the Mt. Bowdoin YM and YWCA and Temple Beth Hillel. These are community based agencies traditionally involved at the time of a death in the family.

now widowed. Some women thought this was a "terrible thing to call me" and threw the letter away.* Others thought they were "already on a mailing list, now what do these people want?" Still others were impressed with the fact that someone cared, and were reassured by the names of the religious organizations on the letterhead. Some of their reactions were colored by who else was available to talk to.** Some women, therefore, called and told the aide not to come; others chose to let her visit because they lacked the energy to call and refuse

the widow what benefits she is entitled to and how to be sure of getting them. One widow saw this discussion about money as an:

"affirmation of life. It makes you think about what is needed to go on living and reminded me that that's what I have to do."

The aide's willingness to answer questions about her own widowhood seems to give the widow permission to unburden herself.

Many women see widowhood as a social stigma.

the visit. Some simply weren't home when she arrived, but most looked forward to the visit. Many widows subsequently became involved with the program although their initial response to the aides' offer to visit was negative.

Once they sensed there was no ulterior motive in the aides' interest, the fact of the aides' widowhood was the important thing that made it possible for them to become involved. The aide mentions it in her letter but it always comes up early in the actual encounter, either in a face to face visit or on the telephone.

The fact of common widowhood is often discussed through the aides' attempt to clarify how the widow is managing financially. They talk about social security, VA pensions, and the like, and the aide will describe her own experience and clarify for

Sharing Common Problems

The fact of the aide's widowhood seems to make it easier for the new widow to accept her, to talk to her, to ask for advice on problems related to her own widowhood, and to feel as if she can still be part of the mainstream of life—that is, she is not so alone and the only one to whom this could happen. Another widow said:

"Since you are a widow too, when you said you understand I knew you meant it and that was so important. I can't stand sympathy and that's all anyone else could give me."

Pride and an unrealistic wish to be independent seem to get in the way of a relationship between widow and non-widows. The new widow finds the latter's efforts to be helpful clumsy. Often they find themselves providing reassurance rather than being reassured. This does not happen with the aide. The aide is using her own experience as a human being and as a widow to guide her in her encounter with the new widow; she appreciates the real need that exists but never takes the widow's initiative

* This may be why organizations of widowers and widows chose names such as NAIM Conference of Chicago and THEO (They Help Others) in Pittsburgh.

** Many felt that their family and friends sufficed for their current need only to come to an awareness later on that they did not really understand, and were inappropriately impatient with them to recover more quickly than was possible.

away from her. If the widow becomes dependent on the aide, it does not seem to bother either of them at this point in the encounter. This most often will take the form of frequent phone calls, or the aide will drive the widow to the social security office and the like.

The widow explores the common problems of widowhood with the aide.

One woman was worried about her child, who took out his father's picture and talked to it. And another was upset because her daughter wasn't doing well in school anymore. The aide could talk about not knowing how to help a child, could honestly normalize the behavior in the knowledge that with time the child does makes an adjustment, but also recognizing the child's need to mourn which the widow doesn't always see. In the words of one widow:

"I tried not to cry in front of my children. I wanted things to be as normal as possible for them. Then my little one stopped working at school. The teacher said he was depressed. The children felt it wasn't right that things should be the same if their father was dead. They thought I didn't care about him."

As a result of talking to the aide the widow started to show the children her true feelings and her boy's studies began to improve. The aide could talk about their own children, the problems they have now as well as when their husband died and how they saw their husband's death contributing to them. They reported what worked for them and what didn't work, and were receptive of the widow's suggestions for solutions as well. They established with the widow the fact that widowhood is lonely, frustrating, that there is often a bitterness which accompanies it; that you really don't get over it, but get used to it. By so doing they seem to take the fear and

worry out of mourning and give the widow a context for her behavior which she can accept and understand. They see normal grief as extending over time, and counsel patience to the widow.

Often, the aides report that the widow tries to be strong and feels she must avoid being excessively dependent and is inadequate if she requires assistance. This feeling is fostered by people such as her doctor to whom she may complain. She is usually told she will get over it and be strong. The aide, on the other hand encourages the widow to return to get a physical check-up to verify that her symptoms are indeed just "nerves." If the doctor prescribes tranquilizers, the aide encourages the widow to use them and not to feel that she is weak and defective for needing this "crutch" in order to get through this period until she learns to find her way in her new circumstances. Over and over again the aide is told:

"You understand the void in my life."

The aide sees this as meaning that it is not always necessary to talk about it because they indeed do know.

The aide is not trying to make the widow into what she is not nor does she want her to act as she, the aide, did, but rather to accept the fact that she is going through hell to be more accepting of herself and her own needs at this time. This is something that the widow reports she does not learn from her immediate family or friends. If she does, it is because there are widows among them.

One woman was worried about her child, who took out his father's picture and talked to it. And another was upset because her daughter wasn't doing well in school anymore.

Learning To Live As a Widow

The aides talk of the needs of the widow to change from seeing herself as married to thinking of herself as widowed. This they see as the first step to recovery.

The aides identify three themes in this process. First is the need to learn to make decisions independently or unilaterally, that is, without the guidance and help of a husband: * *"The biggest decision I ever made was what loaf of bread to buy."*

The second theme is the need to learn to be alone: *"What do I do after the children are asleep? I can't stand the empty silence, and I can't watch another T.V. program."*

The third theme follows on these two in that there is a growing need to make new friends and be out with people: *"I don't get invited out by our couple friends anymore. I'm not always comfortable with them. It makes me feel even lonelier."*

As far as decision making is concerned, the aide is primarily helpful in two ways. She is not afraid to give direct advice if it is needed. She seems more willing to do this early in the contact when the widow seems confused and needs direction about for example, money, children, selling the house and so forth. In the latter phase of accommodation she is more apt to offer encouragement, ideas and support; though she is often quite pointed in telling the new widow she needs to act for herself. For a woman who has seen herself, for most of her adult life, as a partner in a marriage,

this is not always an easy transition to make. We begin to differentiate between those widows who respond to this encouragement, get a job, learn to drive and begin to re-pattern their lives, and those widows (a small minority) who have difficulty. This latter group seems to cling to the past and to be searching for a replacement for their deceased husband who will make their decisions for them. Often they try to put the aide in this role but at this point in time she seems to instinctively repel this effort while not rejecting the widow herself. The program is too young to know how the aides can help this latter group of women pass this stumbling block.² **

To fill the loneliness of any empty evening is not easy. The aide in part helps by being available, if only on the telephone, to talk and to empathize with the problem which she, too, is experiencing. Some widows run away from this by never being home, others put all their energy into taking care of the children. The aide tries to help find a middle road. She acknowledges aloud for the widow that the consequence of running is that one day she will suddenly have no place to go and then she will be really depressed. The problem for the aide is to offer real alternatives for the widow. This brings us to the third theme which involves helping the widow expand her resources and repeople her life differently. Out of this the widow can create for herself alternatives with which to cope with her aloneness and her loneliness.

The aides have helped in two ways: They

* Mrs. Ruth Abrams, research social worker in the Conjugal Bereavement Study at the LOCP has observed that in the first months after her husband's demise the new widow leans heavily on his wishes and her memories of him, and tries to do things as he would have wanted. Recovery, she observed, begins when the widow can "give up her husband's ghost", which means she is able to learn to make decisions based on her current reality.

** In a survey of psychiatric clinic records I noted that most widows who appeared for treatment, came for the first time two years after the death of their husband. These patients may come from this group, and it may be that the effort now, at the end of the first year of bereavement, may have the greatest payoff to prevent a serious emotional disturbance from developing.

have helped the widows find other groups of "single" people where they might find common interests. There are several kinds of single groups. One such group is being formed by widows who have been served by the program. They met at several large meetings arranged by the aides to discuss the problems of widowhood. Several cook-outs were also planned. These group meetings have attracted women who initially refused to see the aide or spoke to her only on the telephone. Once they came to a meeting they returned because they found:

"It helps to talk to others in the same situation. Sometimes when I get home and think about what other women have said I learn something new about myself. The only reason I came in the first place was because I was embarrassed to refuse (the aide's invitation) again. If I had realized how friendly and nice everyone is I wouldn't have been so reluctant."

Another group of women have sought out single people clubs where it is possible to meet men. These women have relied on the aide to inform them about such groups and have asked her to take them to a meeting to overcome their initial shyness.

The second way of helping has been to get these widows to reach out to other widows in their immediate neighborhood who have refused to see the aide, or who are so physically disabled that they cannot leave home. This provides the widow with an opportunity to do something for someone else as well as to make new friends. Some widows seem ready for this by the end of the first 18 months of their bereavement; and the aides are eager to share with them their role as caregiver.

As the widows move out into the role of caregiver it seems appropriate to consider ways of making them more responsible for the ultimate life of the widow to widow

program. The next phase of new activity should involve the widows served in the workings of the program. As they were helped so they can help others and thus give the program continuity and a permanent status in the community. The program is still going on.* We are only beginning to understand the unique role of the widow caregiver. At this point, however, it is possible to say the evidence seems to support our initial hypothesis that another widow is the appropriate intervener in a program of preventive intervention where the client group did not ask for the service.

Discussion

The purpose of any program in preventive intervention is to prevent emotional breakdown in a vulnerable population. While, at this point, we cannot demonstrate that we are achieving this goal in the Widow to Widow Program, it becomes clear that the aides are indeed being very helpful to the widows they reach and that in good part their ability to do so is a consequence of their being widowed themselves.

To better understand the special quality of the aides' helpfulness, two basic problems facing a new widow need examination. The first problem is that of facing the fact of widowhood; that is, accepting their changed marital status and all this involves. The second problem is to learn to manage their own lives, and to demonstrate to themselves and others that they can be and are independent.

Many women see widowhood as a social stigma. They see themselves as marked women, different from everyone else, even

* During the first year the program was supported in part by the National and New England Funeral Directors Association and in part under Grant MH-03442 NIMH. This latter support will continue for another 2 years.

carrying this so far as to see themselves as defective, that something must be wrong with them if they lost their husbands. In addition, all widows report they experience a growing social isolation as time passes after their husband's death. They no longer belong with their married friends, who they find gradually withdrawing from them. They can no longer conform to standards which society calls "normal" and they become people in a "special situation", that is, with a stigma. Goffman¹ describes this phenomenon but it is beyond the scope of this paper to explore all its ramifications for understanding the problems of widowhood. He, however, describes the function of the veteran of this role in helping the newly stigmatized person accept his lot. This is exactly the work of the widow aide. Goffman points to the need of the stigmatized individual to feel that:

"he is human and 'essentially' normal in spite of appearances and in spite of his own self-doubts. . . . The first set of sympathetic others is of course those who share his stigma. Knowing from their own experience what it is like to have this particular stigma some of them can provide the individual with instruction in the tricks of the trade and with a circle of lament to which he can withdraw for moral support and for the comfort of feeling at home, at ease, accepted as a person who really is like any other normal person."¹

Goffman further notes that the veteran serves as an example of someone who can successfully live with his stigma. In addition he functions as a bridge person to the outside world helping them to normalize and be more accepting of people in this category. First, however, they must help the new member accept his own membership in the category. The aide understands instinctively the new widow's reluctance and resistance to accepting this status. The widow is not unique in this. Goffman notes the difficulty the alcoholic, the deaf, and so

forth have in accepting their assignment to a special category. However when they do so, their hope for "normalizing" their life is increased and adjustment or recovery can be achieved. In accepting help from another member of the category they take the first step toward accepting their own membership. By the very nature of the problem then, the veteran, in this case another widow, is best equipped to help the new member. She is first a bridge to accepting the role of widow and then to helping the widow find a place for herself in the larger

What I am advocating is the development of a self help organization. It may be that this kind of organization is best suited to do the work of preventive intervention.

community. In addition, the veteran has a privileged communication with the new member which no outsider can have. The aide can say things about being a member of the category: about feelings (positive and negative), about problems it creates which if mentioned by a non-member would be considered an intrusion or an impertinence. Intervention becomes the work of the members of the category and we begin to understand the success of such self help groups as Alcoholics Anonymous and Parents Without Partners.

There is also a progression in the organization. The members move from initially being recipients of service to becoming providers of service. As a provider of service he develops a sense of independence and adequacy which brings him well on to the road of recovery, accommodation, or adjustment. This is the second need a widow has and as she in turn becomes a caregiver she develops a new sense of independence and worth. Insofar as the Widow to Widow

Program can do this, it should be able to accomplish its goal of preventing emotional breakdown in a new widow.

The self help group has several important characteristics. Primary among them are: that the caregiver has the same disability as the carereceiver; that a recipient of service can change roles to become a caregiver; and all policy and program is decided by a membership whose chief qualification is that they at one time qualified and were recipients of the services of the organization. The prototype for self help groups has been Alcoholics Anonymous, run by alcoholics for alcoholics. This program has assiduously remained independent of the formal health and welfare system, using professionals only as occasional consultants, never to make policy or direct a program.

What I am advocating is the development of a self help organization. It may be that this kind of organization is best suited to do the work of preventive intervention. What problems arise for a self help group begun in a Laboratory of a Medical School? Are these problems different for such a program started in a Community Mental Health Center or clinics.

Many mental health agencies have attempted to replicate some aspects of the success of these self help groups by employing so called "non-professional indigenous workers." Unlike A.A. these non-professionals are usually given extensive training and supervision so that they begin to adopt professional values and emulate professional techniques. If they were following the self help model, they should be making policy, developing their own techniques for helping, and the consumer of their services should be able to move into their role of caregiver. In the average agency setting this would be difficult to achieve since it would mean that the professionally trained caregiver could be displaced by his former

client. He could also potentially lose control of policy as well as of practice. This would be inappropriate and inconsistent with the mandate an agency has from the community supporting it. The goal, as I see it, should be a partnership between independent self help groups and the formal agency whose special expertise is utilized as needed.

The Laboratory of Community Psychiatry at Harvard Medical School is a research and training center and has no commitment to serve a particular population. Nor is it an agency committed to any particular technology. It does not have a staff who would be offering an additional or competing service and whose position would be threatened if clients became caregivers. It is therefore feasible for the Laboratory of Community Psychiatry to experiment in sponsoring a self help program staffed by non-professionals who meet all the requirements for being potential recipients of the service themselves. Here is a unique opportunity to learn how to stimulate the development of such organizations to do the work of prevention, to learn what form an on-going organization can take in the community, and to experiment with different forms of collaboration between the formal agency and the emerging self help group.

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Boris M. Levinson, Ph.D.

The New York City Skid Row Negro: Some Research Findings

A study of the New York City skid row Negro discloses the effects of racial, social and economic discrimination on intellectual and personality structure. Most of these men, many of whom are from the South, are either semiskilled or unskilled workers. They have a mean WAIS full scale IQ of 85, the verbal IQ being higher than the performance IQ. An analysis of data from a study of 24 matched WAIS full-scale IQs of northern and southern homeless Negro men indicated no significant differences in the factor measures for the two groups. This would seem to imply that racial, cultural and economic deprivation, whether in the North or in the South, has the same debilitating effects.

Extent of the Problem

It is estimated that there are 34,000 homeless men in New York City.¹ The Bowery has a population of 7,000 homeless men.² One-third of them are Negro. In the year 1969, the Shelter Care Center for Men of the Department of Social Services of the City of New York assisted 3,885 homeless Negroes for an average of 31:0 days each (estimated by writer from 1969 Annual Report of the Shelter Care Center for Men).

Dr. Levinson is a professor of psychology in the Department of Educational Psychology and Guidance, Ferkauf Graduate School of Humanities and Social Sciences, Yeshiva University, New York, N.Y. 10003.

Generally speaking, the homeless man, particularly the homeless Negro, is not an isolated phenomenon. He is part and parcel of the main current of American life. Thus, the composition of the skid row population reflects the socio-economic composition of the lower strata of the city, its environs and its inner immigration. It is not the locus or the cesspool toward which all the ne'er-do-wells or mental defectives gravitate or a gathering place for "down at the heel," alcoholic businessmen, artists, poets, and college professors.

This article is adapted and updated from a paper presented at the symposium, "Negro Life in 1967", held in December 1967 at the Fall Meeting of the New Jersey Psychological Association.

Background

As is well known, the Negro people are now undergoing a revolutionary transformation in their mode of thinking, living, and working. They have changed from a predominantly agricultural people to an urban one. As a matter of fact, today the Negro is more likely to be a city-dweller than the white man.¹⁶

We thus find that thirty years ago, there were almost three million sharecroppers and tenant farmers in the 16 southern states. Today, there are fewer than 380,000, of whom 120,000 are sharecroppers. A majority of those displaced are Negroes, who are forced off the land at a rate double that of white farmers. "Many have exchanged their 'cabin in the cotton' for the broken down truck or shack of the migrant worker."¹⁷

This transformation has been accompanied by a decline in the standard of living of the majority of Negroes. While it is true that economic conditions, employment opportunities, and general living conditions have tremendously improved for the middle-class Negro, this has not benefited the lower-class Negro. Whereas in 1930 the number of unemployed Negroes was comparable with that of whites, this is no

an absolute decrease in manufacturing jobs. Thus in New York the drop was 8.27%; in Philadelphia, 3.9%; in Newark, 3.1%; and in Pittsburgh, 4.7%."¹⁸

In a sense, the skid row Negro is reenacting the history of the white immigrant of fifty years ago. With the progressive urbanization of the Negro, there has been an increase in the number of homeless Negroes on skid row.

This can be highlighted by the following: During the depression (1935), only seven to twelve percent of the unattached transients were Negro.⁸ In Chicago in 1934, 15 percent of the unattached persons applying for relief were Negroes. It is to be noted that these men were not considered homeless, but only unemployed. Of course, a small number of them were also homeless. However, the estimated number of Negroes on skid row in Chicago in 1957-58 was already 9.2 percent. Correspondingly, during the same period the estimated number of Negroes on Philadelphia's skid row was 14.7 percent; and in Minneapolis, it was 4.5 percent. The numbers have since risen appreciably.

To illustrate, in a study conducted in 1945, the percentage of Negroes among homeless men was eight.⁹ This increased

Unlike the migrant worker, the homeless Negro rarely has a nostalgic yearning for the past . . .

longer true; and, as is well known, the rate of unemployment among non-whites is now twice that among whites.¹⁴ There has been a decrease in the need for unskilled labor in both the South and the North. Over one-third of the nation's Negroes were in agriculture in 1930; less than a tenth were in agriculture in 1960. "However, the Negroes coming to the city coincided with

to 22 percent in 1955,¹¹ and, in 1965-66, over one-third of the homeless population was Negro.¹² These studies have revealed that over two-thirds of the New York skid row Negroes are from the South.¹³ This finding has been corroborated for New York City⁸ and for Chicago.¹

When unattached Negro men arrive in New York City, have no family or friends

on segmented and narrow life experiences, could not fail but be reflected in the WAIS scores. Furthermore, we know that these men possess certain survival skills, developed as a result of their aversive life experiences, that are not measured by the WAIS.

It is instructive to observe that social and economic deprivation, no matter in what context it occurs, has a similar effect on cognitive abilities.

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Richard T. Goldberg, Ed.D.

Jane Stein

The Role of the Psychiatric Consultant in the State Rehabilitation Agency

A study of the use of psychiatric consultants showed that counselors in a state rehabilitation agency used them to evaluate clients' eligibility for services. Once the case was accepted, the counselor rarely turned to the consultant for services. The authors believe that this infrequent use may be a result of role conflicts and suggest that roles be redefined to make the consultant more of a tutor than arbiter of case determination.

The extension of psychiatric consultation to community agencies and large organizations has been a subject of considerable discussion. Some have felt that the traditional image of the doctor as healer of patients may be seriously distorted and impaired by the assumption of consultative roles unrelated to patient care. This problem becomes particularly acute when the psychiatrist is requested to function as an evaluator, as consultant to the courts, or as member of an admissions committee.² In these roles, he is clearly functioning as administrator, not healer. A less clear situation is presented by the psychiatrist func-

tioning in a college clinic servicing the needs of students with maladaptive behavior. The college psychiatrist is faced with the dilemma of treating the student for clinical reasons or of intervening in behalf of the student to circumvent the rules of the bureaucracy in alleviating the student's stress.³ A third situation is one in which the psychiatrist functions as both evaluator and healer for large organizations such as corporations, government, and social welfare agencies which refer an employee or potential recipient of services for an evaluation to assess emotional strengths and weaknesses. As a result of the psychiatric report, the person undergoing evaluation may qualify or be rejected for services, may be retained or fired, or may be placed in a quasi-therapeutic regimen in

Dr. Goldberg is Director of Research at the Massachusetts Rehabilitation Commission, 296 Boylston Street, Boston. Miss Stein was a research assistant at the time of the study.

which his eligibility for continued services or continued employment is made dependent upon obtaining psychotherapy.

The role of the psychiatric consultant in the state rehabilitation agency is crucial in the selection and acceptance of referrals of persons with diagnosis of mental disability. The formal role of the psychiatric consultant requires him to review and evaluate

Some counselors feel that the psychiatrist has the final word on acceptance of a psychiatric client for service, despite the fact that the determination of eligibility is clearly outlined in the counselor's duties.

the history of persons with mental disability by means of medical records, to complete the medical consultant's appraisal form, to assist in determining the limitations of the client for work and to give recommendations on which clinics, hospitals, and psychiatric specialists can provide further diagnosis and/or treatment when needed. Upon request, the consultant also reviews the history of persons with secondary psychiatric involvement. Since the records of every person with mental disability must be reviewed prior to acceptance of the person for rehabilitation services, the psychiatric consultant wields considerable power in the administrative procedures of the state rehabilitation agency.

Methods and Subjects

In order to analyze the role of the psychiatric consultant and to determine the extent to which it is fulfilled, an operational research study was conducted in a large, urban office of a state rehabilitation agency. This office housed a group of 14

rehabilitation counselors with varied educational and work experiences. A majority had master's degrees, and seven of the 14 had some specialized training in vocational rehabilitation. With the exception of three persons, their work experiences in vocational rehabilitation ranged from one to seven years, with a mean of three and a half years. Their experience as counselors in the state agency ranged from one to seven years. Twelve counselors were carrying general caseloads and two were carrying predominantly mental disability caseloads. In educational and work background, they were similar to other counselors employed by the agency. The setting was representative of a public agency located in a crowded, urban area. The staff was overburdened by demands for increasing services from a large caseload. Staff was constantly struggling to keep up with the demands, and one line supervisor was expected to handle 14 counselors.

During a six-month interval, 191 persons with mental disability were referred for determination of eligibility for vocational rehabilitation services. Of the 191, 161 had a diagnosis of primary mental disability, including psychosis, psychoneurosis, alcoholism, drug addiction, and personality and character disorder. An additional 30 clients were referred with secondary psychiatric disorders. Whereas psychosis accounted for 46 percent of primary mental disability referrals, it accounted for only seven percent of secondary psychiatric referrals. This situation was reversed for personality and character disorders: they constituted 50 percent of secondary referrals and only 17 percent of primary referrals. Psychoneurotics constituted approximately two fifths of both groups. Although no explanation of this variation in diagnosis can be given with certainty, it can be inferred from the pat-

tern of referral sources that primary disability referrals generally came from the state mental hospitals, where the diagnosis of psychosis was most frequently given, and secondary referrals came more frequently from the community, or from hospitals other than mental hospitals. Ten clients with secondary psychiatric disability had a primary diagnosis of mental retardation, and eight had a diagnosis of epilepsy.

Each client of the agency was followed for a minimum of six months and a maximum of one year from the date of referral. An investigation of individual case records was the primary source of data for the analysis of the use of the psychiatric consultant in evaluation of individual cases. The notes of the mental health supervisor who had presented cases to the psychiatric consultant during the study period were made available. In addition, the investigators were permitted to sit as observers of the sessions with the psychiatric consultant in which individual counselors presented cases for review.

A questionnaire was constructed and given to the counselors to determine their perceptions of the role of the psychiatric consultant. The questionnaire was broken into two parts: the first part consisted of generalized statements about the consultant and elicited overall global attitudes; the second part consisted of defining the consultant's role in a number of specific areas and determining the extent to which the counselor perceived the consultant as helpful in fulfilling his role.

Findings

Sixty-one percent of the sample were presented to the psychiatric consultant for evaluation and review. Fifty-four percent of persons with diagnosis of primary mental disability were reviewed whereas all with

secondary mental disability were seen. With one exception, all active cases (both open and closed) were reviewed, whereas only 26 percent of those cases still in referral at time of study or closed in referral were seen.

Persons with mental disability who are accepted for rehabilitation services (active status) must be evaluated by the psychiatric consultant. Other persons may be closed from referral without the benefit of the consultant's advice. That all clients with secondary disability were reviewed is an artifact of the study, since secondary psychiatric disabilities were identified by means of the consultant's list of clients evaluated.

In order to determine the extent to which the psychiatric consultant is used, the number of times and stages when cases were presented for review were measured. Sixteen percent of the 117 persons presented for psychiatric appraisal were seen for additional consultation more than once. Ninety-three percent of the cases presented for appraisal were reviewed once before acceptance. Of the 11 cases seen after acceptance, six were persons with primary physical disability in whom psychiatric symptoms became manifest after acceptance for rehabilitation services. Except for five persons, all with diagnosis of primary mental disability were seen before acceptance for services. Counselors did not obtain psychiatric consultation while clients were receiving rehabilitation services.

In analyzing counselors' attitudes toward the psychiatric consultant, two indicators of attitude were taken. First, generalized statements about the role of the consultant were presented for approval or disapproval on a five point scale. Second, counselors were asked to rate the helpfulness of the consultant in a number of key areas and to determine whether these areas legiti-

mately fall within the consultant's role. These areas included: evaluation of the client; determination of eligibility; determination of existence of disability; determination of work potential; determination of need for therapy; how to most effectively deal with the client; clarification of vocational goals; gaining realistic expectations for the client; formulation of an occupational plan; and determination of readiness for training.

On the whole, counselors held favorable attitudes toward the consultant in their responses to the generalized statements. Two counselors held negative attitudes toward the consultant, four held strongly positive attitudes, and the remaining were positive. Counselors generally were in agreement on the following items: the consultant's effective use of his time; the signing of necessary forms; respecting the role of the counselor; helping the counselor to understand better his client. Less agreement was obtained on items concerning the counselor's attitude toward the consultant's recommendations. Counselors were divided on whether to follow or to resist the recommendations. There was also disagreement on whether the consultant is guided by the counselor's understanding of the case.

The second indicator of attitude toward the consultant was obtained by taking discrepancy scores between how helpful the consultant was perceived to be in certain areas and how important the consultant's role should be in similar areas. On the whole, there was minimal discrepancy between what the counselor perceived that the role of the consultant should be and how helpful the counselor found the consultant in carrying out his role. Counselors felt the consultant should hold a strong role in total evaluation of the client, determination of existence of disability, de-

termination of need for therapy, how to deal effectively with the client, and giving realistic expectations for the client. It was felt that the consultant had a moderate role in the determination of work potential, the clarification of vocational goals, and the determination of readiness for training. Counselors felt that the consultant's role in the formulation of the occupational plan should be either minimal or non-existent. The item on determination of eligibility produced an equivalent response among counselors; half of them thought it definitely fell within the consultant's role and half thought it was not his role. In addition, it was thought that counselors who held a more favorable attitude toward the consultant would be less discrepant in their perceptions of what the consultant's role should be and how helpful the consultant was in carrying out his role. This hypothesis was rejected, although a strong relationship was found between favorable attitudes and less discrepancy.

Discussion

The role of the psychiatric consultant in the state rehabilitation agency needs to be clarified. Although the consultant's role and duties have been formally outlined in the state manual of operations, his informal role may be quite different. A distinction needs to be drawn between the consultant's formal role in reviewing and evaluating client records and his informal role in providing guidance in the counseling of a psychiatric client during the rehabilitation process. This study indicated that counselors tended to use the consultant as an evaluator or approval agent for clients which the counselor wanted to accept or reject for services. After the case was accepted, counselors infrequently returned to the psychiatrist for help in case services.

One explanation for minimal contact between counselor and psychiatrist during the rehabilitation process may be role conflict between the two professions. Counselors feel that they are trained and qualified to manage the vocational problems of their clients. Moreover, some counselors with client-centered orientation might feel that counseling and therapy are synonymous. From this vantage point, they are performing a therapeutic function comparable to that of the psychiatrist. In bringing their cases for review to the psychiatrist, a person who holds greater prestige value in the professional community, counselors may feel they are jeopardizing their own professional role and function. Counselors might be fearful of being judged on their professional treatment of the case, or of being analyzed by the psychiatrist. Therefore, they tend to bring the case for appraisal, but are reluctant to return to the psychiatrist for advice and guidance.

Another explanation might be that the counselor feels threatened by emotional problems. They might be unwilling to spend a long period in reevaluation of clients with baffling emotional problems requiring complex treatment and resources and with uncertain vocational outcome. These clients differ from the physical restoration case requiring diagnosis and hospitalization, or from the school case requiring further vocational training. If vocational problems were the only consideration, then the counselor of the emotionally disturbed would be more secure in his role as vocational expert.

Counselors' perceptions of the role of the psychiatrist vary greatly. They are divided on the question of whether the consultant or counselor determines eligibility. Some counselors feel that the psychiatrist has the final word on acceptance

of a psychiatric client for service, despite the fact that the determination of eligibility is clearly outlined in the counselor's duties. Counselors are doubtful of their own responsibility to establish eligibility and to come to some decision on acceptance or rejection of their clients. By reliance upon the psychiatrist the counselor is able to postpone making a decision until the psychiatrist has appraised the case.

The psychiatric consultant, when functioning in the role of administrator, poses a threat to overburdened, underpaid mental health counselors and case workers.

Attitudes toward the use of the psychiatric consultant vary greatly among individual counselors. Counselors might be quite willing to accept the psychiatrist's appraisal of the case, but unwilling to follow his recommendations for further diagnosis and therapy. When the psychiatrist impinges upon the counselor's role as coordinator of case services, the psychiatrist holds less power in the rehabilitation process than when he acts as an evaluative agent.

Recommendations for further clarification of the psychiatric consultant's role might include differentiation from that of the medical consultant, who appraises the functional capacities of the disabled person, determines the limitations existing in regard to disability, discusses the extent of disability, and evaluates the medical prognosis.⁴ After this has been determined, the medical consultant's role is minimal with the exception of cases where recommendations for surgery and hospitalization are required. Although the psychiatric consultant follows the procedural format of

the medical consultant, he may function in a broader way. He may be used more extensively as teacher and advisor in establishing a therapeutic relationship with emotionally disturbed clients. With few professionals available for counseling and treating the emotionally disturbed, the psychiatric consultant might be used effectively in his tutorial role without seriously impinging upon the counselor's role as vocational expert or counselor-therapist.

The implications for psychiatric consultation in community agencies are many. The psychiatric consultant, when functioning in the role of administrator, poses a threat to overburdened, underpaid mental health counselors and case workers. These professionals may see the psychiatrist not as a supportive arm in the provision of mental health services, but as a judge of their capabilities in counseling the emotionally disturbed. This perception of the psychiatrist's role is strengthened when the administrative and legal procedure such as in the state rehabilitation agency requires a positive appraisal before services may be rendered. It is contended that the psychiatric consultant has another role: tutor and advisor. This role can be enlarged when he is perceived in a coordinate position in relation to the counselor. The administration and coordination of case services, including eligibility determination, rests solely with the counselor. When counselors are secure in their own roles, the use of the psychiatric consultant at any point along the rehabilitation continuum from referral to job placement will be increased, broadened, and intensified.

The findings in this study raise the question whether the psychiatric consultant can function optimally as tutor in a context where the counselor brings his cases routinely and perhaps involuntarily to the psychiatrist for appraisal. The tutorial

type of consultation requires free interchange between consultant and consultee in which a relationship of trust is built between the two active participants. The consultee must feel free to bring his problems without suffering a sense of guilt due to personal inadequacy or mismanagement of clients.¹ A relationship of trust can be developed where the psychiatrist functions in a non-administrative role in relation to the counselor.

Perhaps the role of the psychiatric consultant in the state rehabilitation agency should be divided between two persons functioning differently: a psychiatric consultant in the administration of the mental health program; and a psychiatric consultant with the counseling relationship between counselors and clients. The first person would act primarily as an administrative consultant to the mental health and district supervisors. He might also encourage group discussions for counselors and district supervisors as joint participants to increase group cohesiveness and stimulate a feeling of participation in administrative policy. The second person would act primarily as tutor to counselors, including in his functions education, explanation, interpretation, and guidance with individual problems.

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Anne S. Evans, S.M., A.C.S.W.

Margaret F. Goldberg, M.S.W., A.C.S.W.

Catholic Seminarians in a Secular Institution

Thirteen Maryknoll Seminarians joined the Case Aide Program at Boston State Hospital. They worked with four women and nine men, typical of patients found in the back wards of state hospitals. As a result of the seminarians' intervention, most of the patients were able to develop a warm trusting relationship, and to take on greater responsibilities both in and outside the hospital. Research concluded that the seminarians' preoccupation with self-knowledge was considerably greater than that of Harvard Student groups previously tested, and was in keeping with the purpose of the novice year: to decide upon the priesthood as a career. The overall assessment score of the effectiveness of the volunteer as a therapeutic trainee was considerably higher for the seminarian group than for the Harvard Student group.*

The Case Aide Program

The Case Aide Volunteer training and demonstration model at the Boston State Hospital had as its purpose to: (1) Provide patients and volunteers with a meaningful one-to-one relationship under skilled super-

Mrs. Evans is the Associate Director and Mrs. Goldberg is Senior Psychiatric Social Work Supervisor of the Case Aide Program at Boston State Hospital, Boston, Mass. 02124.

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vision; and (2) To train and further educate the volunteer in meeting urgent manpower shortages in the State Hospital.

The program, the first and prototype for all state hospital non-student volunteer case aide programs in Massachusetts, first came into being in September 1963 when a small grant from the Permanent Charities Foundation of Boston was made available to demonstrate the theory that intelligent and highly motivated community volun-

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teers, under the supervision of the trained psychiatric social worker, could help chronically ill patients. A result of our initial demonstration showed that the very special way the volunteer intervened with mentally ill patients, a way which could be described therapeutic, partly educational and partly supportive, made possible a surprisingly high degree of patient improvement. This result was identical with that of a project done in the early 1960's with Harvard and Radcliffe volunteers.^{2,4} This student volunteer program was the model for the original volunteer demonstration grant at the hospital.

The Volunteers: The group of 13 Maryknoll Fathers Seminary volunteers unlike other case aide volunteer groups, was the first religiously affiliated group to join the program. These men, between the ages of 21 and 27, were all white and came from devout homes of varying socio-economic backgrounds.

Collectively, for their ages, the life experience of these particular seminarians was far more limited and restricted than for other non-religious student volunteers who have also been members of the Case Aide Program. Every seminarian had graduated from a Catholic supported college, and most of the students had attended a private Catholic supported high school; two attending the seminary for their total secondary school experience. Only one of the group had been in the armed forces prior to his membership in the seminary.

Patient Selection: The patients selected by the supervisors for the seminarians to work with were typical of the long time hospitalized, chronic population, at the Boston State Hospital. They included four women and nine men between the ages of twenty-eight to fifty-six.

Their diagnoses were characteristic of

those found in the back wards of state hospitals. Nine were diagnosed as chronic schizophrenics; of these five were considered to be paranoid, two were catatonic, and two simple type. Two were diagnosed as depressed, and two were diagnosed as having chronic brain syndrome due to alcoholism. Of the thirteen patients chosen, two were Protestant, six Catholic and four Jewish. One was a Chinese born Buddhist.

Supervision: The supervision of the seminarians at the Boston State Hospital was undertaken by two members of the Psychiatric Social Work Staff of the Case Aide Program.

The objectives of supervision were to "tune in" to the individual student in terms of: (1) his ability to establish a rapport with his patient; (2) the goals which might be realistically reached for the patient, as well as; (3) his own needs and capabilities for self-awareness, growth and maturity.

It is the aim of the program that while engaging in "friendship therapy", the volunteer must view himself as a person who has both an interest in, as well as an awareness of, the patient's capacities and limitations. Each seminarian was helped to develop his own particular style with his patient, based upon the recognition of his increasing ease and comfort in dealing with a mentally ill member of society in a chronic ward setting; his own ability to sharpen his skills in assessing the needs, strengths, and liabilities of the patient; and to define, and help work out appropriate goals for the patient. At first this seemed to be an enormous task for the seminarian as he, unlike other college students, or more mature volunteers, had no role model to which he could adapt. His previous experience with people was mainly involved with family or friends and his ex-

It appeared initially that these young men expected to give to their patients, using the role model of a priest "giving" of himself to his parishioners, but not to be the recipient of friendship from his patient.

posure to the community had primarily been in connection with the religious. He had learned that peoples' expectations of him were in terms of the expectations made of a priest, i.e., his ability to eventually offer the sacraments of the church; his future theological expertise; his influence in the missions as a religious pragmatist.

Once the student became comfortable in his relationship with the patient and formed his own impression of the patient's capabilities and limitations, the supervisors then suggested that they look at the hospital records to get further insight and/or a different point of view about the patient, in terms of a clinical diagnosis, prognosis etc. Records were therefore read some three to four months after students had engaged the patient in a relationship.

When situations relating to patients' jobs, home placement, vocational testing, and the like, were deemed appropriate by the students and supervisors, the volunteer was then expected to be the pivotal person to relate to the ward or rehabilitation staff for advice and help in planning. It was with the volunteer's help that specific plans were worked through for the patient.

As a result of the group and individual supervisory sessions, the student became comfortable in his role with the patient, his ability to work independently, develop skills, determine problems and define goals.

The student's rapport with his patient was in most instances both mutually profitable and beneficial. The seminarians learned how to enter into a give-and-take

relationship. It appeared initially that these young men expected to give to their patients, using the role model of a priest "giving" of himself to his parishioners, but not to be the recipient of friendship from his patient.

As the seminarians became more committed to their patients, so too did they become more relaxed and comfortable in the group and individual supervisory setting. For many, this was the first time that they were supervised by a woman, and their first exposure to women whose backgrounds and philosophy was considerably different from their own. The students were young, idealistic, religiously oriented and socially naïve. The supervisors represented the middle-class married mother, part-time professional psychiatric social worker, psycho-dynamically oriented woman, without close religious ties.

The supervisors had much to learn in their understanding of seminary students, primarily, the philosophy of dedicated commitment to the Church and its implications for the individual considering such a vocation. The students were able, as the year went on, to communicate verbally and attitudinally, not only what they individually would be giving up for their belief, but far more importantly; what they felt they could give as professionals in the Church. They viewed the concept of giving as an end unto itself and felt that ideally they would be fulfilled as a result of their involvement as missionaries.

As was expected at the Seminary, several students decided to change their careers during this novice year. Five students chose to leave the Seminary. In every instance, there was discussion with the supervisors regarding their feelings of leaving the seminary, and the system in which they had been nurtured. Advice was sought regarding their future plans. While these

five felt they could no longer remain in the seminary, for various personal reasons, they have all indicated a strong desire to continue to be of help to others. Two subsequently joined the Peace Corps; two are planning careers in psychiatric social work and one is contemplating a vocation in personnel counseling.

According to Father Diffley, a faculty member at the Seminary, the Case Aide Program crystallized the need for a more highly specialized clinical pastoral chaplaincy program. Subsequently, Maryknoll made arrangements for forty-five of their students to work in the Clinical Pastoral Training Program on a two day a week basis with intensive group and individual supervision being offered by pastoral counselors. This program, which was started in October 1968 through the present time, in connection with the Andover Newton Theological Seminary, offers the student a still more intensive educational experience utilizing the novice as a chaplain, a method which in turn clarifies his potential vocational role.

Research Findings

As a part of the Case Aide Program's research, a questionnaire and two scales⁸ were administered for use by the students and their supervisors. One scale was designed to determine the motivation of volunteers coming into, and becoming members of, the Case Aide Program. A second scale, "The Assessment of Therapeutic Trainees", was designed for use by the supervisors in assessing the effectiveness of a volunteer as a therapeutic agent with a mentally ill patient.

Upon coming into the program, the seminarians were required to complete a volunteer questionnaire designed to ascertain descriptive face sheet data, as well as

information regarding motivation for joining the program. The results of this questionnaire strongly indicated that all of the students wanted to be of service to the patient, i.e., to help the mentally ill.

Within a few weeks after the students had been assigned their patient, they were then asked to complete the motivation questionnaire of 56 separate items. The M.Q., as it is called, is composed of seven sub-scales; each relevant to a specific area of motivation for volunteering. The areas are; social, career, escape (from one's environment), mental health knowledge, challenge, self-knowledge and service. The sub-scales of the Maryknoll Seminarians were compared with a group of former Harvard Students previously tested.

Interestingly enough, despite the fact that the students originally answered the initial questionnaire regarding motivation in terms of service to patients, the overwhelming majority (12 of 13) ranked extremely high in the sub-score of self-knowledge. While no test for statistical significance was made, the self-knowledge score was found to be considerably higher for the Maryknoll Seminarian Group (.78) than for a group of Harvard Students (.59).

We wondered why the seminarian was so pre-occupied with self-knowledge and thought about his case aide experience in relation to his activities outside the hospital. As the purpose of the novice year in the Maryknoll Society was to determine whether or not the seminarian was truly serious about his intentions regarding his commitment to the priesthood, it was reasoned that the more self-awareness, insight, or self-knowledge the seminarian had at his command, the clearer and firmer a resolution of his commitment would be to the Church.

As a group, the seminarians' mental health knowledge, escape and career moti-

vation sub-scales were quite low. Thus, this group did not come into the program to learn about mental health, to escape from their environment, or to utilize the case aide experience as a potential career testing ground. The Harvard Students

The seminarians' prime underlying motivation was decidedly one which involved a deepening and broadening of self-awareness.

tested showed approximately twice as high ratings in these three sub-scales. In terms of the remaining three sub-scales; social, challenge, and service, there is little difference percentagewise between the rating for the Maryknoll Group and the Harvard Group.

Generally then, it can be stated that other students we had occasion to supervise, as well as those Harvard Students previously tested, came into the program with very different underlying motivations from those of the seminarians. Often the former were very sophisticated, extremely intelligent, and perceptive and wished to make use of the field work experience at the hospital either to enhance their own theoretical knowledge; to test the possibility of a mental health career or to escape from the college classroom environment. The seminarians' prime underlying motivation was decidedly one which involved a deepening and broadening of self-awareness.

A second scale, *Assessment of Therapeutic Trainees* was designed for use by psychiatric social work supervisors in evaluating characteristics associated with therapeutic competence.¹ Each supervisor in the Case Aide Program was asked to assess every volunteer in his group on the 27 items included in the scale. The scales were to be completed after the supervisor felt he knew the volunteers well enough to make such an assessment. For the group of seminarians, the scales were completed

some five to six months after the group entered the program.

The total mean score for thirteen seminarians was 23.4. Their score was considerably higher than for thirty-one Harvard Students previously tested, the latter's

total mean score being 17.3. Sub-score comparisons between the Seminarian Group and the Harvard Group could not be made as the latter sub-scores were not available at the time of this writing.

In attempting to understand and name the qualities of the effective volunteer (a high assessment score) it is useful to look at the items themselves. The first sub-score describes a person who is *tolerant, empathic, and compassionate*. As expected, the seminarians scored extremely high in this sub-score. Out of nine items in the sub-score, ten students totaled either eight or nine. One would surmise that tolerance, empathy and compassion for one's fellow man are traits as important to the successful priest as to the successful mental health case aide volunteer.

In respect to the second sub-score; that of describing the person who *respects the dignity of the patient as an individual*, and does not need to emphasize *status differences*, once again, the seminarians scored extremely high.

The third sub-score concerned itself with the volunteer's *involvement in the therapeutic process* such as being flexible and capable of *imagination and spontaneity* in trying out new approaches for solving the patient's problems. Ten students, of the thirteen, received a "perfect score" in this area. Contrary to the supervisors' early expectations in comparing their own experience with other student and non-stu-

dent groups in the program, the authors believed that the Seminary Groups' continuity and initiative were somewhat lacking. Their creativity and imagination seemed more repressed when they first came into the program than other groups.

The items in the fourth subscale depicted an objective and emotionally controlled person who had self-insight and was not hampered by outstanding personality limitations which disrupted his work with patients. The Seminary Group, as a whole, scored lower on this item (six received perfect scores) than on the previous subscores. The Supervisors' rating of the groups' need to gain self-insight, as seen in this subscore, was most certainly in accord with the high "self-knowledge" subscore in the motivation questionnaire previously described.

The fifth and sixth subscales were involved with good relationships with patients and good relations with supervisors. In both these areas the students scored very well. The research documents much of the material already discussed.

The seventh subscale concerned itself with the volunteers' capacity to learn and grow. Over half (7) of the group received a perfect score of seven, while four more scored six points. One might assume that students would score well in this area, otherwise, they probably would be wasting their time in an academic environment.

The eighth subscore described the volunteer as psychologically sensitive and trying

to understand his patient as a complex human being. The result of this subscale (10 received perfect scores) was not pleasing as one, once again, must assume that sensitivity to people is a personality prerequisite for the priesthood.

Finally, the effective volunteer was generally optimistic about therapeutic outcome. He showed the ability to sustain high interest and involvement and backed up his faith in the patient and his commitment to the patient's progress with energy, initiative, and action. The high score that the seminarians received in this subscore reflect his overall faith and lifetime commitment to God and man.

It was felt that utilizing seminary students in the Case Aide Program at the Boston State Hospital has been a most rewarding experience for the patients, the students and their supervisors.

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Walter Tietz, M.D.

School Phobia and the Fear of Death

It has been known for some time that the psychodynamics in school phobia could be best understood as a variant of separation anxiety.² Furthermore, it has also been observed that school phobia is part of a natural history of depressive disorder and that there seems to be a depressive family constellation in the school phobic, occurring in successive generations.¹ The prognosis in school phobia seems somewhat dependent on age. It is relatively good in children prior to adolescence and relatively poor in older children.¹ In younger children the dynamics of separation anxiety are prominent; whereas in older children there is more widespread inauthentic characterologic family disorder where a depressive family constellation dominates. It is the purpose of this paper to present a series of cases of school phobia occurring in adolescents from 11-15 years old, all associated with death in the family, where the school phobia served as a facade for the real fear which was fear of death. An attempt will be made to understand this in the theoretical framework provided by Bowlby.

Case Histories

Case 1

Patient is a 14-year old white female, who developed psychosomatic complaints and school

Dr Tietz is Assistant Clinical Professor of Child Psychiatry and Pediatrics at the University of Southern California Medical Center, 1200 North Main Street, Los Angeles, Calif. 90033

phobia shortly after her maternal grandmother's death, which was coincidentally followed by a move of the family to a new section of the country where there was no extended family. The mother was an intensely phobic woman always fearing the death of her own mother and was extremely overprotective to her children because she had always feared some harm might come to them. The patient became obsessed with fear of her own mother's demise and became afraid she too would die.

Case 2

Patient is a 15-year old white male, who became acutely disturbed about two months after a serious accident where he was severely crushed, incurring a fracture of the arm. He began to feel weak, helpless, and felt he could not exist without his mother being constantly with him, resulting in his failure to go to school. The patient literally felt he would die if he were not with his parents. Furthermore, the father also was obsessed with the fear of death.

Case 3

Patient is a 14-year old white female, who developed psychosomatic complaints and intense school phobia when, one and a half years after her grandfather died, her maternal grandmother who was dying of cancer moved into her home. She was afraid that her mother might also die, leaving her alone, susceptible to death. As a result she was afraid to go to sleep, equating sleep with death, and afraid to go to school because then her mother might die.

Case 4

Patient is a 12-year old white female, who became acutely upset when her mother had to leave for the 12am to attend the funeral of the maternal grandmother. She began to develop

various psychosomatic complaints, and finally would not go to school at all.

Case 5

Patient is a 12-year old white male, who had been extremely anxious for the past four months, since his paternal grandfather died in Israel. The father had gone to Israel and stayed there for a month. Upon his return, the father became irritable, anxious and depressed. About two weeks after the father's return, the boy became frightened, had various psychosomatic complaints, and refused to be left alone. He always wanted one of his parents to be at home with him, and he refused to go to school. He verbalized the fact that he was afraid something might happen to them, especially his father. When the parents would leave him, he would go into the room with his sister in order not to be alone.

Case 6

Patient is an 11-year old white male, who had had a school phobia ever since he started school. When he started school at age six, his father had been dead for one year, following a bleeding duodenal ulcer. His mother and paternal grandmother, who moved in with them, constantly reminded him of his father's death. The death of the remaining two brothers of his father over the ensuing years only intensified the feelings of loss of his father. Furthermore, the family belonged to a religious sect which predicted the death and destruction of mankind in the next few years. The boy was constantly afraid his mother might die and that this would leave him helpless and weak. He became depressed and developed suicidal ideation, while at the same time he was afraid of his own death and destruction.

Discussion

Thus, it can be seen that death, or fear of death can be a precipitating event in the genesis of a school phobia. In all the cases presented here, there was not only a school phobia, an active death or fear of death of the parent, but it was also always associated with a fear of the child's own death.

How can this best be understood? John-

son⁹ and her co-workers have suggested that the syndrome of school phobia be redefined in terms of an etiologic diagnosis, namely, separation anxiety. Johnson has defined separation anxiety⁹ "As a pathological emotional state in which child and parent are involved in a relationship characterized by an intense need on the part of both to be in close physical proximity." Spierling¹⁰ sees school phobia as a neurosis characterized by fixation at the anal-sadistic level, the time where individuation and separation should occur. It thus represents a failure to resolve the normal infantile symbiotic relationship the mother has with the child, and is interpreted as an acute separation threat which has the implied meaning of impending death.

The problem of separation anxiety and its relationship to grief and mourning has been studied intensively by Bowlby. According to Bowlby,² the child develops a tie to the mother as a direct outcome of the activation of a number of instinctual response systems among which are crying, smiling, sucking, clinging and following. When these instinctual response systems are activated and the mother figure is temporarily not available, the response is one of separation anxiety.³ When the mother figure appears to be permanently absent, the response is one of grief and mourning.⁴

Thus, the relationship of separation anxiety and mourning is determined by the temporary or permanent absence of the mother figure. Viewed in this light the clinical observance of the association of school phobia in the child and depression and depressive constellation in the family, can be readily understood.

Furthermore, if one feels that the attachment behavior to the mother is basically instinctual and has survival value, failure to resolve this attachment and separate successfully, would cast doubt on

The association of school phobia and death in the family may be fortuitous and may not be causally related, but it does seem to affect the prognosis when school phobia does develop.

one's ability to exist autonomously. Thus, failure to dissolve this pre-oedipal bond means failure of ego autonomy and implies ego dissolution.

The relationship of depression to separation of the infant from the mother figure had earlier been described by Spitz.¹¹ He described a syndrome occurring in infants in the second half of the first year of life at which time the infants were separated from their mothers for a period of three months or more. The infants lost their means of emotional support and therefore developed an "anaclitic depression" manifested by sadness, withdrawal, slowness of movement, loss of appetite, and loss of weight. This became very serious and actually had a high mortality with it. In addition to the high mortality, followup studies on these infants showed some retardation of development.

It is possible that in the cases of school phobia described in this paper, the feared loss of the mother figure was not only manifested by separation anxiety and school phobia, but also by an "anaclitic depression," in Spitz's sense. The fear of their own death which all these cases showed, may be a direct outcome of an "anaclitic depression." Thus, the feared loss of the mother figure on which to lean on or depend on, caused a feeling of vulnerability, manifested by their fear of their own death.

As a result of a number of studies,^{5, 8, 8} it has been postulated that the effects of early separation are hidden, and later re-

peated experiences of loss reactivate the processes originating in the earlier loss. Bowlby feels that studies reporting an association between childhood mourning and later depressive states are significant because of the similarity he discerns between grief and mourning in an adult and the despair phase of response to separation in an infant. He feels that the defensive detachment following the despair phase of childhood mourning precludes a healthy working through of grief in the child and later predisposes him to depressive reactions.

In the cases reported here, the association of separation anxiety, manifested by the school phobia in the child, and a death in the family were concomitant. The death tended to start the process of grief and mourning and in a circular fashion reactivate the feelings of anxiety associated with separation. The sequence of events was the exact reverse of the usual manner grief and mourning proceed.

There, as described by Bowlby,^{3, 4} the phase of protest, separation anxiety, is succeeded by a phase of despair, or grief. In these cases reported here grief occurs first, and then is followed by separation anxiety, manifested by school phobia.

It should be noted that the cases presented are mostly in the older age group which is associated with a poorer prognosis. The association of school phobia and death in the family may be fortuitous and may not be causally related, but it does seem to affect the prognosis when school phobia does develop. It seems fairly obvious that school phobia will not inevitably develop in every child when an actual death occurs in a family. Bowlby has felt that the effect of the mother's disappearance or death is related to a critical time in the child's development, namely from six months to three years.^{3, 4}

If the mother is absent in that period a serious characterologic effect may appear in the child. Nevertheless, it would be interesting to study children where death has occurred in the family and no school phobia develops. In this way the coping mechanisms can be better understood.

Summary

Six cases of school phobia occurring in adolescents ranging in age from 11 to 15 years old are presented. In all the cases there is an association of school phobia, an active or feared death in the family, and a fear of the adolescent's own death. Using the frame of reference provided by Bowlby, school phobia can be understood as failure to resolve the normal attachment behavior. Its failure becomes linked up symbolically with failure to exist as an independent person, resulting in a school phobia. The presence of an active death in the family does seem to affect the prognosis once a school phobia does develop.

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Eugene J. Faux, M.D.

Blaine Crawford, M.S.W.

Deaths in a Youth Program

The authors discuss eleven deaths that occurred in a series of 595 patients admitted to the Utah State Hospital Youth Program over a six-year period. They consider five of these deaths to have been preventable. Since four of these five took place among patients assigned to the same geographic unit, it seems reasonable to assume that they are related to staff attitudes and hospital living experiences.

It is well known that children who have sufficient problems to enter state hospitals have a higher than average death rate. They tend to be accident prone, abrasive and depressed. Since the beginning of the Utah State Hospital Youth Program six years ago, records have been kept concerning all deaths.

This paper will discuss the reasons for these deaths and the possibility that some of them could have been prevented.

This program is the only residential treatment program for children in the state and as such has admitted 595 patients over the six-year period. These children were grossly decompensated and were usually not admitted unless local community services had been exhausted.

During this time children were required to live on the adult wards, which were divided into the geographic unit system. Each unit had its own professional staff, attendants and two to four wards.

Dr. Faux and Mr. Crawford are with the Utah State Hospital, Box 270, Provo, Utah 84601.

Eleven deaths took place—five during hospitalization and six after hospitalization. The causes ranged from a motorcycle accident to three suicides, one possible suicide and one murder. Unit I had two deaths, Unit II had one, Unit III had seven and Unit IV had one. Unit V, with the largest average daily census of young people and adults, had no deaths.

The youngsters in this sample, who ranged from age 13 to 19, had had their professional treatment and schooling in a day program separate from the rest of the hospital. All the hospitalized young people return at night to their respective wards on the adult units. Utmost cooperation is necessary between the two professional teams involved.

The authors will now take great liberties with this paper and record their subjective impressions in a general way as it concerned each adult unit, their attitudes about children and the type of experiences with the youngsters and staff.

Unit I

Interested in children, wanted to help, good staff rapport, permissive attitude, always available for conferences about children, some resistance to acting out patients.

Unit II

Positive attitude about children and a desire to help. Cooperative and available at all times, permissive in their approach. The children liked their dorm and staff. Worked well with acting out as well as withdrawn youngsters.

Unit III

Passive cooperation at first with gradual resistance and antagonism to children as responsibilities were felt. Intolerant of acting out patients and insisted only psychotics should be admitted. Antagonized the children and Youth Center staff. Boycotted staff seminars and when there rebelliously insisted that most mental illness was a myth. Finally refused to allow any children on their wards and the other units had to take care of them.

Unit IV

Cooperative and helpful. Positive most of the time. Had some of our most difficult cases to help with and did so without complaining. Permissive in approach. Available for conferences. Tends to resist acting out patients.

Unit V

This unit has a tremendous morale and handles the largest case load in the hospital. Responsibilities are taken religiously with children, even volunteering additional help or ideas. The children feel they are on a good unit, but complain that the policies are restrictive. There is a discipli-

nary attitude and strong therapeutic community type program. Personnel work equally well with psychotic and acting out patients.

Discussion

After analyzing this particular series of deaths the authors have concluded that five of them were preventable. Case I was in Unit II. The other four were in Unit III.

Case 1

This was a 15-year-old mentally retarded boy who had been in the hospital several years before the Youth Program began. He was taken for granted as a long-term problem and yearly physical examinations were not done. He never complained and took care of himself without much assistance. One day in the shower room an attendant noticed he had a large testicle which proved to be very malignant and the cause of his death.

... one night (he) hanged himself after making numerous threats to do so. He had been regarded as a ... nuisance who made frequent suicide gestures, but, who seemed unlikely to harm himself seriously.

Case 2

This 14-year-old girl was in the hospital several months before the Youth Program was initiated. She came from a broken home, having been deserted by her mother in infancy. She failed to prosper after almost a year's hospitalization. The father and stepmother made it plain they did not want her back in their home. At this point her natural mother appeared at the hospital, having lived all these years in an-

other state. She requested the patient's release, saying she was financially successful and capable of assuming responsibility for her daughter. The father at first objected but later joined his ex-wife in requesting the patient's release. Since she was a voluntary admission she was discharged. One and one-half years later we learned she had hanged herself in a girl's reformatory in the mother's home state.

She was a treatment failure in our institution and we hopefully and naively felt she could adjust when reunited with her mother.

Case 3

This boy came from a broken home, and experienced severe rejection by both of his parents. After unsuccessful private care he was admitted to the Utah State Hospital Youth Program but persuaded the judge to release him when he had his hearing. One and a half years later he was admitted as an adult patient making suicidal threats and cutting himself. He could not get along in the hospital and one night hanged himself after making numerous threats to do so. He had been regarded as a poorly motivated antisocial nuisance who made frequent suicide gestures, but, who seemed unlikely to harm himself seriously. Very few precautions were taken and supervision was lax.

Case 4

This girl was admitted at age 10 when Child Welfare workers claimed she had exhausted her foster home and school. She seemed to only be antagonized by hospital-

ization but failed also to adjust when another foster home was tried. On her second admission her regular unit would not accept her and she was transferred to another ward. She and another female teenager went AWOL claiming to have had a sexual escapade with boys they picked up. They called the police afterward and asked to be returned to the Hospital. Subsequently the program for her was restrictive. One night after a temper outburst she was found hanged by a sheet in her seclusion cell.

Case 9

This 19-year-old epileptic girl was extremely paranoid and abrasive. She could never prosper in the Hospital and seemed to go from bad to worse. She was found dead while at home on a trial visit and had taken an overdose of barbiturates.

Psychiatric treatment was a complete failure and she expressed hatred for the Hospital.

Conclusions

Four, and possibly five, of these cases were suicides. Since they were assigned to the same geographic unit and since no other unit in the Hospital had this difficulty it seems appropriate to relate these tragedies to staff attitudes and hospital living experiences.*

* The authors are currently working on a study to further identify living problems for our children as they occur in our Hospital. A later publication will define the social static on the respective units in a less subjective fashion.

Herbert G. Richek, M.S.W.

Clyde D. Mayo, M.S.

Herbert B. Puryear, Ph.D.

Dogmatism, Religiosity and Mental Health in College Students

Data of this study were used to test the hypothesis that the more dogmatic an individual is, the less secure he is. Ss were 166 lower division students at a small denominational university who completed the MMPI and the Dogmatism scale and who also provided information on their religiousness. The hypothesis was supported for religious females but not for males; in the latter group, it was found that high dogmatism scores were associated with "mentally healthier" scores on the MMPI scales of Hypochondriasis, Psychopathic Deviate and Schizophrenia.

In his seminal work, *The Open and Closed Mind*, Rokeach³ reported a significant positive relationship between dogmatism (as measured by his scale) and anxiety. The relationship, however, did not prevail in all samples—thus, religious subjects who were dogmatic were also anxious, whereas advocates of authoritarian political beliefs who scored high on the D (Dogmatism) scale were low on the anxiety measure. All subjects were college students; the politically dogmatic Ss, how-

ever, were in attendance at English institutions while the religious Ss were Americans. The speculations offered by Rokeach to account for the discrepant findings are not germane here; Rokeach proffered the explanation that religious beliefs may not be effective as an "anxiety reducing agent."

Rokeach's postulated relationship between dogmatism and anxiety received support in the investigation by Korn and Giddan¹ of the construct validity of the Rokeach D scale. These investigators found a significant negative correlation between D scale scores and the California Psychological Inventory (CPI) Well-Being scale scores, (Ss were 195 male college freshmen); they state that the correlation

Mr. Richek is Assistant Professor in the School of Social Work, University of Oklahoma, Norman, Okla. 73069. Mr. Mayo is a doctoral candidate in psychology at the University of Houston, Houston, Texas, and Dr. Puryear is Associate Professor of Psychology, Trinity University, San Antonio, Texas.

indicates that ". . . the more dogmatic an individual is . . . the less secure he is." It should be mentioned that the religiosity of the college students was not a variable of interest in this investigation.

For religious females, however, dogmatism does appear to be negatively associated with mental health.

The purpose of the present study was to re-investigate the relationship of dogmatism, religiosity and mental health in lower division college students. The results appear to be sharply at variance with the Rokeach⁸ and Korn and Giddan¹ findings and cast doubt on the unqualified hypothesis that dogmatism is inversely related to indices of mental health in college students.

Procedure

The following data were obtained from 166 freshman and sophomore college students: Dogmatism (D) Scale scores; MMPI scores (in raw form) for the 10 standard clinical scales, three validity scales (L, F and K) and Anxiety (A), Repression (R) and Ego Strength (ES). Subjects also responded to questions regarding their church affiliation and whether they considered themselves to be religious or non-religious. The data were collected as part of another investigation.² The MMPI scores were used to provide measures of mental health.

Since there are sex differences on the MMPI scores in raw form, four groups were initially defined: Religious females (N=78), Non-religious females (N=21), Religious Males (N=45) and Non-religious males (N=22).

A correlational analysis revealed several significant associations between the D scale scores and certain of the MMPI variables. Therefore, all four groups of Ss were further categorized as low or high dogmatic (divided at the median) and the groups were compared using the MMPI scales as the dependent variables.

Results

Males

The findings of the comparison between high dogmatic and low dogmatic religious males are certainly in conflict with those of Rokeach and Korn and Giddan. The more dogmatic religious males scored significantly lower on three MMPI clinical scales: Hypochondriasis, Psychopathic Deviate and Schizophrenia.

Females

Korn and Giddan did not address themselves to the relationship of dogmatism and psychological well-being in female college students, but Rokeach's conclusions apparently hold both for males and females. For the religious females in this study, the more dogmatic the subject is, the more depressed, the more psychasthenic and the more anxious she is (although this latter relationship is three hundredths of a point removed from statistical significance).

Discussion

That the findings *vis à vis* the religious males in this investigation are not in accord with the statement: ". . . the more dogmatic an individual is . . . the less secure he is" appears evident. It is difficult to accept a position that higher Hypochondriasis, Psychopathic Deviate and

Schizophrenia scores are indices of "security" or "well-being"! For religious females, however, dogmatism does appear to be negatively associated with mental health.

The difference in results may possibly be accounted for in a number of ways; for one thing, the MMPI, the CPI Scales and the scale Rokeach used as an index of anxiety provide differing measures of personal and social adjustment. Also, scholastic aptitude is a variable of influence, and such data were not available on our subjects. In this connection, it should be noted that Korn and Giddan found a significant inverse relationship to exist between both verbal and quantitative aptitude and dogmatism in males; for females, they found only the negative correlation between verbal aptitude and dogmatism to be significant. Finally, religiosity of the Ss was not a variable in the Korn and Giddan study and the extent to which this may account for the discrepant findings between our study and theirs is not known.

It would, however, appear safe to conclude that Rokeach's assertion that religiosity may not be effective as an "anxiety reducing agent" warrants re-investigation, at least in male college students; our data support the Rokeach hypothesis only for religious dogmatic females. In fact, continued investigation of the relationship between dogmatism and mental health along with the study of a variety of contingent factors might have considerable theoretical as well as practical significance for mental health professionals in university settings.

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Alex D. Pokorny, M.D.

Correlating the Fifteen Indices with Hospital Achievement Awards

Fifteen Indices¹ was a publication designed to bring out the relative standing of the states in support of mental health programs. The general goal was to help in obtaining adequate support for such programs. It was intended for use in public education, legislative hearings, and in self-evaluation by the officials and citizens of each state.

Fifteen Indices first appeared in 1957 and was reissued at two-year intervals until 1968. It is now under study for revision. We would expect that the states that scored high on the indices would be the ones with better programs, but this is difficult to judge without using the same items which make up the indices. One outside criterion which should identify quality in state mental health programs is the distribution of the American Psychiatric Association's Mental Hospital Achievement Awards² (recently renamed Hospital and Community Psychiatry Achievement Awards). These have been given for the past twenty years, thus overlapping completely the period during which Fifteen Indices was published.

This report presents a comparison of the states with respect to their standing in the Fifteen Indices and their numbers of Achievement Awards. The data published in Fifteen Indices for 1956 (in some instances 1955 or 1957) were used, because these

dates fall in the approximate midpoint of the 20-year Achievement Award period. Only the 48 contiguous states were studied, because data for Hawaii and Alaska were largely unavailable for that time. With regard to the APA Achievement Awards, the entire period of 1949-1968 was used. Only those awards which were given for state programs were included (omitting those for VA, city, county, private, and community programs not administered by the state). The total number of awards given to the 48 states was 52, including honorable mention awards. This is admittedly a small number for statistical manipulations, but this was the total number available. Initially a weighted system was tried, giving more credit for first and second prizes, but this turned out to correlate .98 with a simple count of numbers of awards. Accordingly, the latter was used in the calculations reported here.

The Fifteen Indices, as those familiar with this document will realize, tend to reflect related and at times overlapping items (e.g., "per capita general state expenditures" and "per capita general state and local expenditures"). Thus, it was decided to reduce the 15 indices to a smaller number of dimensions or groupings by the technique of factor analysis (principal axis with varimax rotation).

Three factors emerged, which have been

Dr. Pokorny is Professor and Acting Chairman, Dept. of Psychiatry, Baylor College of Medicine, Houston, Texas 77025, and Chief of Psychiatry, VA Hospital, Houston.

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labeled: I. "Advantaged Status"; II. "Understaffed, Low-cost Program"; and III. "Low State Government Spending." The 15 indices grouped readily into these three factors,* with high correlations or loadings.

Evidently some states manage to have well-staffed and well-financed public mental health programs even though they have only average general state spending levels . . .

The three factors were then correlated with the numbers of awards for the period 1949-1968, and with the population of each state as given by the 1960 census. One interesting finding was that Factors II and III had negligible correlations with total population (.09 and .05), whereas Factor I, "Advantaged Status," was significantly and positively related to population (product-moment correlation of .41). This indicates that the more populous states tend to be the more advantaged in such terms as income, numbers of psychiatrists, and expenditures for public mental hospitals.

It should be recognized, however, that the more populous states also have larger numbers of state mental hospitals and other state institutions and programs, and thus have more potential candidates for an award. Indeed, the number of awards during 1949-1968 was found to be correlated .45 with population, confirming that more populous states with more institutions receive more awards. This confounding influence of population was therefore removed by the technique of partial correla-

* Factor I is made up of Indices 1, 6, 7, 8, 11, 12, 14 and 15; Factor II of 2, 3, 4 and 5; Factor III of 9, 10 and 13. The loadings range from .66 to .95, and some of the correlations are negative (inverse).

tion. As a result, the number of awards showed no significant relationship to Factor I (Advantaged Status) or Factor III (Low State Government Spending). The number of awards did, however, show a strong inverse relationship ($r = -.59$) with Factor II (Understaffed, Low-cost Program); the states which get awards for their state mental health programs are those which score low on this factor; that is, they are better staffed and have higher costing programs. The same relationships hold when the award period is split into two ten-year periods.

It is somewhat surprising that "Advantaged Status" shows no significant relationship after the effect of larger population is removed. Likewise, a low general level of state spending (Factor III) does not show any relationship to number of awards. Evidently some states manage to have well-staffed and well-financed public mental health programs even though they have only average general state spending levels, and they also manage to get their share of the awards.

It would appear, therefore, that at least some of the fifteen indices do indicate which states will receive more awards for innovative and outstanding mental hospitals and mental health programs; these are the items most directly related to staffing and funding of public mental hospitals. An incidental finding is that the fifteen indices are somewhat overlapping and redundant; they group readily into three factors or clusters of items.

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Rudolph F. Wagner, Ph.D.

Secondary emotional reactions in children with learning disabilities

This discussion is based on the assumption, or willful suspension of disbelief, that disabilities in children do exist. It is further assumed that the learning disability is primary, and the emotional reactions to such disability are secondary in nature. The existence of primary emotional disturbances with symptomatic learning disabilities is not denied here. The subject will be approached on two levels: namely, (1) developmental psychological aspects of emotional reactions; and (2) possible remedial therapeutic efforts and techniques for treating these secondary signs.

Developmental Psychological Aspects

Before a youngster enters school he is usually a happy fellow even though he may potentially have a reading problem. The misery of the dyslexic child starts at the threshold of the school building! He will first try to fool the teacher by learning whole passages by heart since he is endowed with at least average intelligence.

Dr. Wagner is Chief Psychologist, Richmond Public Schools, 312 North Ninth Street, Richmond, Va. 23219. This article is based on an address given before the Orton Society, Capital Branch, in Bethesda, Md. in November 1969.

At the end of the first grade he will be in the lowest reading group in class. His reading is labored, words are omitted, consonantal clusters are reversed. Someone might have already called him a dummy.

This is the point where the secondary emotional reactions have their origin. The child reacts to continuous failure and to social ridicule by showing the first signs of an awareness that he is a failure. This reaction is provoked in two ways: first from within by affecting the budding self image; and secondly from without by being told about the poor performance. The emotional reactions are not specific to the learning disability but are the child's basic personality, only made more intense by provocation: the shy one gets shyer, the extrovert becomes aggressive, and the mildly anxious youngster may become phobic. Their reaction is expressed in hiding, avoiding or even denying the disability. An inferiority complex develops. The danger exists now that these gradually emerging emotional reactions may become permanently imbedded in the child's behavioral patterns, even after academic remediation has been instigated. They may become functionally autonomous.

However, the beginning of academic

remediation usually brings about a partial cessation of secondary emotional reactions. Four categories of emotional reactions can be discerned among those suffering from this agony as a byproduct of learning disabilities:

1. Defense and Avoidance Mechanisms, for example falsification of signatures, losing report cards, refusal to read, avoidance of books, etc.

2. Compensatory Mechanisms, such as developing behavior problems, foolishness in class, bragging, clowning while others read, or dressing up to the teeth.

3. Aggressiveness, either overt or covert, such as fighting on the yard, critical remarks, bothering others, making biting comments or throwing spitballs.

4. Anxiety and Withdrawal, behaviorally manifested in dependence, depression, day-dreaming, regressive tendencies, or various fears.

The last two categories above may also develop into psychosomatic complaints with a variety of symptoms. Girls seem to be less affected by emotional reactions to failure than boys in the same way as the ratio of boys to girls is disproportionate (approximately 4:1). There are few children with learning disabilities, somewhere up to 10 percent, who show no emotional reactions, but this may well depend on the depth of the psychodiagnostic evaluation.

Remediation and Therapy

Treatment of emotional reactions to primary learning disabilities, if at all attempted separate from remediation efforts focusing on the academic disability, are available and may involve various techniques. Among the better known are:

1. Tutorial Relationship. Remediation procedures usually call for a small class environment and a 1:1 basis of teacher-child

relationship. It should be realized that this relationship is not only necessary for the conquest of academic deficiencies but seems to prepare the therapeutic conditions that are also conducive to the treatment of emotional reactions. This is of paramount importance with regard to the qualifications of the remedial or Special Education teacher who must be trained not only in academic remediation but also in counseling therapy.

2. Supportive Counseling. Counseling should be a byproduct of any academic remediation effort. It can be carried out by the school counselor or school psychologist in cases of mild-to-moderate severity. Supportive counseling is just as important for the child as it is for his parents.

3. Psychotherapy. In severe cases of emotional reactions, psychotherapy is indicated, usually provided by psychiatrists and well-trained psychologists.

4. Medication. At this stage, medication can be regarded only as a concomitant treatment, side by side with counseling or psychotherapy. Drug therapy still lacks the specificity needed to be directed towards specific symptoms. At best a child may be made amenable to treatment or remediation. The hyperactive may calm down more, or the anxious might be less apprehensive.

5. Behavior Modification. In recent years, operant conditioning techniques have been used successfully with all types of behavior, including learning disabilities. The technique may be carried out by the classroom teacher or parent, under supervision and after instruction from appropriate professional consultants.

6. Curriculum Modification. The subject of whether a dyslexic child should remain in the classroom or be isolated into special remediation groups is still controversial. However, one philosophy is

that the child should remain in the regular class where the non academic courses could be taught (physical education, art, shop, etc.), while the skill subjects would be offered in small groups, but in the same school, by qualified special teachers.

One of the assumed advantages here would be that the child remains with his peers, possibly lessening the severity of emotional reactions. On the other hand, the child may become more aware of his disability if he is isolated and may have to face social demands once he leaves the sheltered special class.

To this writer, the ideal solution—as yet far away from reality—is the amalgamation of child-oriented theories and task-oriented theories. A dyslexic child fights the language system; he is “normal” otherwise. If the given language system would not require left-right discrimination, consonantal blends, stringing of letters to make a word that stands for one idea—then he

would have a chance to beat the reading game in our culture. There is a clash between the human and the task system which must be overcome first. Our “normal” children seem to be able to read in spite of the clash of two systems. But a large percentage of children cannot cope with these incompatibilities between man and task systems. Something has to give before we can look for the breakthrough in special education. Some remedial methodologies for teaching reading have tried to make a dent into the dimensions of a task-system by altering the alphabet and orthography of a given language (e.g., “i.t.a.”, or Laubach), but at the end of the line the children taught by these methods face the cold reality of our English language usage: it is different from what was taught to them, and the moment of truth, the transition, has come. This is where failure once again may knock at the door of the “cured” disabled learner.

Law, Society and Mental Illness

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Community mental health and the criminal justice system, Shah;

Development of community mental health programs in the civil area; Woloshin and Goldberg;

Titicut follies revisited: a long range plan for the mentally disordered offender in Massachusetts, McGarry;

New York's mental hygiene law—a preliminary evaluation, Zitrin, Herman and Kumasaka;

Who is competent to make a will?, Weihofen and Usdin;

A radical view of social welfare and mental health, Ginsberg.

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Perspectives of Military and Civilian Retirement

This paper will attempt to compare and contrast some potential and actual difficulties in two large retirement populations—the military* and the civilian. Important areas of social and personal conflict and of potential psychopathology developed in coping with the stress of retirement will be indicated. A comparison of the organic health problems in military and civilian retirees will not be attempted here. It is hoped that the comparisons made will aid counselors and therapists in recognizing conflicts in adjustment of both the civilian and military retirees and in advising them accordingly.

Definition of Retirement

A precise definition of retirement or of its requirements exists neither for the military nor for the civilian retiree. Whether one is retired may depend on age, labor force participation, or physical and mental condition. Conditions of declining health and physical capacity usually are given as reasons for the need for retirement of civilians in the lower occupational statuses.

Dr. Bellino was a senior psychiatric resident at the University of Florida and Gainesville VA Hospital when this paper was written. Requests for reprints may be sent to him at Suite 11, Perrine Plaza, 417 12th St. West, Bradenton, Fla. 33505.

In the military, and in a large segment of the higher civilian occupational statuses, withdrawal from the work force occurs because of a formal retirement system.

Only in the last several decades has civilian retirement emerged as a social pattern, while military retirement has been an expected termination of a career for a much longer period. In general, civilian retirement is considered to be an accrued benefit for the individual, serving to guard him against the difficulties of old age. In reality, retirement for both the civilian and military work forces is usually a consequence of institutional needs and interests.

For all retirees, retirement is an event which marks a turning point in their life histories. Retirement is both a status and a process for all individuals. Accepting a status of retirement can lead to stability and a realization that the individual will have a retirement status until death. The

* Many good sociological studies have dealt with the problems of the civilian retiree but none has dealt with the military retiree.¹⁰ However, several articles have recently appeared in medical journals describing a pre-retirement syndrome in military personnel.¹⁻⁸ We have recently published a paper for Florida physicians in which we attempted to define the post-retirement problems of the military retiree and offer suggestions for treatment.⁹

retirement process is the orderly transition from one period of life to another, leading to new interpersonal and social adjustment.

Financial Problems of the Retiree

At retirement the typical civilian retiree is about 65 years old. His children are no longer dependent on him—a fact which reduces the minimum income needed for subsistence. His retirement benefits usually consist of a pension which is intended to provide a reasonable measure of income, but which in fact provides only a minimum subsistence level.

Absence from home may have enabled the couple or family to adjust to or accept a relationship which under conditions of closer contact may be strained.

The military retiree is about 42 years old after a 20-year career. He generally has a wife and two or more dependent children, all of whom are accustomed to a certain prestige and standard of living. At the present time a chief petty officer with 20 years of service can expect to receive a retirement income of about 250 dollars per month. His financial and social expectations make his pension too small for retirement to be a leisurely period or an acceptable status. He does fare somewhat better financially than the civilian because he has access to added benefits such as completely free medical care and commissary privileges.

In America the social status of the family is often associated with the occupational position of the head of the household. In addition to status, our society largely defines success as money, activity, and youth. In our culture these factors are also intimately associated with work. The military

retiree maintains his youth, and financial needs necessitate continued employment with its concomitant activity. The need then for success i.e. work is a constant pressure on him.

The civilian and the military retiree are handicapped in finding employment as both are heir to labor market prejudices. Employers often prefer to fill positions from within their own ranks with younger men who have developed within the company. In addition, employers often feel that retirees can be hired at reduced salaries because of their retirement pensions. This supplemental income may further cause problems with unions and fellow employees. Unions often exert pressure on employers to hire younger men who have no retirement pensions. Fellow employees may harbor resentment against the retiree and envy the extra income which supplements his salary. The military retiree is further handicapped by the fact that some of his skills cannot be carried into the civilian labor market, and he often lacks employment information which might aid his integration into the labor market.

Interpersonal and Social Problems of the Retiree

Community acceptance, social status, and residence are areas of conflict for the military retiree immediately on retirement. The civilian who has community roots and retains the same friends and social ties does not experience so disruptive a change.

In a 20-year military career, the careerist, often accompanied by his family, has had six to eight separate assignments in many geographical areas where he had no intention of living permanently. He has been unable to develop lasting ties with any civilian community, with its social groups, established neighbors, churches and

schools, which might ease the changeover to civilian life.

Few professions or occupations throw individuals and families into such close social relationships with colleagues as does military life. Very quickly families learn that rank has privileges and provides a ready made social position. The serviceman and his family incorporate the value system to which they have become accustomed. As retirement approaches, the family and the retiree feel the impact of the loss of a way of life that has proved secure and satisfying. Then, unlike the civilian family, they must search and find a completely different social position in a new subculture that provides even fewer guidelines for them than it does for the retiring civilian family who do not have to so completely reorganize their lives.

Civilian and military retirees have a similar problem in the extra amount of time they will initially spend at home. Absence from home may have enabled the couple or family to adjust to or accept a relationship which under conditions of closer contact may be strained. At retirement, interpersonal relations must be extended by at least eight hours each day. This adjustment may be more of a problem for the military family, as military commitments have often separated them for extended periods. Even when the military retiree finds employment he spends relatively more time at home than ever before.

The military retiree has no counseling either verbal or written except in the area of financial benefits.

The wife, due to her husband's absences, may have learned to be the decision maker—a role she may not wish to or know how

to relinquish. Finding himself without the usual means of self-expression through work, the civilian or the military retiree may elect to express himself in a situation in which the available role is already well filled by his wife. He may try out a new role at home as homemaker, advisor, or head of the household. This period of adjustment is particularly stressful for the retiree who needs the support of a good marital relationship. Attempts at usurping his wife's responsibilities expose the retiring person to his spouse's hostility at a time when his defenses may be weakened by role confusion and by the loss of social status. The difficulties of this period are especially acute for the military retiree who is seeking a totally new self expression.

Counseling Problems

Counseling services, although limited in scope, are available to some civilian retirees. However, industries employing large numbers of workers are avidly seeking a more meaningful psychological and sociological approach in counseling their retirees. Currently, information on finances, physical and mental health, use of leisure, and geographical relocation is available at retirement. Even with its limited availability, this interest in the civilian retiree's future welfare tends to focus his attention toward planning for a meaningful retirement.

The military retiree has no counseling either verbal or written except in the area of financial benefits. One reason for this lack of information is that, until recently, the military's attention has not been drawn to the adjustment problems of the retiree before and after retirement. The retiree often makes his own plans. Employment and relocation are the main foci of his planning and the lack of counseling may allow him to assume that no particular

social or personal difficulties are anticipated for him.

Comment

In psychiatry, prevention of mental illness has only recently gained impetus. Unlike other areas of medicine where clear cut disease entities can be isolated and studied, in mental hygiene difficulty arises because causality and precursors of signs and symptoms of emotional illness have not yet been thoroughly identified. Social parameters and their relationship to individual stress have not been defined in many areas of social interaction, which further complicates preventative measures. Community psychiatry, the field which has been implementing mental hygiene principles into programs of mental health, now realizes that to be truly effective, sociological and medical principles must be applied to any intervention techniques. We feel that the military retiree represents a relatively homogeneous subculture. The study of that subculture could cut across sociological and medical lines, and thus permit application of sociological techniques to a mental health model and implement a truly preventive hygiene movement. Seldom do we find such a large group of people with similar life histories and subculture to study social and personal conflict as we do with the military retirees. We may be able to clarify general trends in the civilian and military retirees by contrasting the attitudes and role changes in the two groups, thereby anticipating individual difficulties.

Summary

This paper attempts to highlight areas of conflict for retiring civilian and military

personnel. Comparing the military and civilian retirees, the former is considered unemployed. Differences in interpersonal, social and financial stresses are discussed, pointing out varying intensities of problems mutually experienced by the civilian and military retiree. The reasons for the need for further studies in retirement conflicts are discussed.

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Sven Lundstedt, Ph.D.

Conflict Management: Preeminent Challenge

Primary Elements in Social Conflicts

Social conflict cannot be understood without reference to the existence of at least two or more parties which may be individuals or, in a corporate sense, groups and organizations.

Conflicts can also exist within a person as conflicts of psychological motives and attitudes, including the behavior of the conscience. Individuals may be in conflict with themselves, but such a "personal" form of conflict usually arises with reference to a specific relationship with an external person or object. Conflicts of a personal nature are very often a significant event in social organizations. Moral conflict (conscience) or conflicts of thought and purpose will affect, often deeply, the outcome of social conflicts.

The Arena of Conflict

Kenneth Boulding¹ describes two elementary kinds of social acts which occur in any engagement with an adversary. They

are called *conflict moves* and *trading moves* respectively. Successful trading results in both parties gaining something. Conflict results in gains for at least one party and some losses for the other. Occasionally both lose. Mutual loss is a special outcome of conflict behavior in which neither party may have full control over a final outcome. Conflict always has a "win-lose" quality.

Fortunately, all conflicts are not irretrievably hopeless. Often they are changed into trading by such compromises as bribes and side payments. Negotiation and bargaining, strictly speaking, is a procedure by which a particular conflict field is explored to find the best available trading moves. But as soon as all available trading moves in a particular field of conflict are exhausted, the parties are left with an "irreducible minimum" of conflict. If the leftover conflicts are unimportant to the further survival of either party, each may lose interest. If the remaining conflicts are serious enough, the relationship between the two can become a crisis and deadlock. New methods of conflict management are then imperative. The "relevant states," or value systems, in the conflict field have to be re-examined to find ways to break the deadlock. But this analysis so far is still not enough.

Dr. Lundstedt is Professor of Public Administration and Social Psychology in the College of Administrative Science at Ohio State University, 1775 South College Road, Columbus, Ohio 43210. This article is adapted from one which appeared in the *Bulletin of Business Research*, January 1969.

Attitudes and Motivation

Two psychological dimensions are also necessary to a further understanding of social conflict. Social attitudes is one and motivation the other. If we should ask why conflict and trading occur, other concepts would be required to help explain the *source of action*. Conflict and trading are *motivated* behaviors. The final objective of all motivated behavior in people (barring exceptional cases) is psychological and physical survival and the maintenance of optimum conditions for continuing growth.

All conflict and trading behavior can be said to be motivated by reward or punishment. Experimental research and common sense overwhelmingly support the interpretation that people are attracted by the promise of pleasure and the reduction of pain. On the other hand, pain irritates, angers, and then repels or provokes attack. But conflict and trading are also motivated by reasoning and reasoned choices among alternatives, especially in the selection of avenues for achieving personal or group goals which appear rewarding.

People, groups, or organizations can hardly be expected to bargain rationally even in their own interests in the face of hostile attitudes, mistrust, and anger that are aroused by mutual punishment.

Memory and Anticipation

We think about social relations not only in terms of anticipated future but also in terms of immediate and past memory (both emotional and intellectual) of earlier pleasure or pain. Conflict and trading behavior no doubt reflect the influence of long- and

short-term memories to a far greater extent than we may know at present. As for plans and anticipation, it is fair to say that most people regard the future in terms of a subjective probability wherein either winning or losing in a conflict is expressed along a scale of values in which long- and short-term memories of former reward and punishment play an important part. To argue that people, and ultimately groups and organizations, do not use reason in an effort to ensure for themselves and their groups a maximization of gains over losses is certainly a non sequitur. It is hardly logical to think that most sensible people are indifferent to their relative chances for survival.

Only when minimal human requirements for survival have been met can generosity and cooperation begin to take on concrete meaning. Paradoxically, though, under some conditions people may be able to express these sentiments even when deep dissatisfaction and personal suffering are evident. People can express humane, social wants and sentiments even under duress provided, of course, that too much duress does not exist.

Generosity also leads to reciprocity. George Homans² tells us that human social exchanges are a form of "economic" reciprocity.

Reward and punishment also markedly affect intellectual commitment. In trading, when one is consistently rewarded, thoughts about one's adversary should tend to become favorable. When two or more parties continue to be mutually rewarded the relationship between them eventually should improve.

Attitudes

When we think, feel, and prepare to act toward some one or some thing we are said

to have an attitude toward it. These three elements form the structure of a single attitude, and, thus, an aspect of our psychological posture. Thought, feeling, and a readiness to act are obviously of great importance in understanding conflict and trading behavior, and ultimately conflict management. In fact, we know a great deal when we know the true attitudes of another, and, accordingly, we can plan better by anticipating his intended strategies.

On the basis of this we can examine common mistakes and methods of confrontation.

Two Methods of Confrontation

1. *Dueling.* This method of confrontation has been inherent in generalized conflict, such as total war, where adversaries may lose heavily. The inevitable "win-lose" quality that arises in total war traps contenders in cycles of behavior that can lead to mutual destruction. Naturally, since each will work only in terms of his own self-interest and survival to the exclusion of the other, each may become irrevocably trapped within this behavior pattern. It is this particular blind alley that so decidedly helps to shape the final outcome of such conflict and sets narrow limits upon the opportunities that may become available for its resolution. People, groups, or organizations can hardly be expected to bargain rationally even in their own interests in the face of hostile attitudes, mistrust, and anger that are aroused by mutual punishment. Indeed the dilemma is a form of "conflict trap" often with no visible way out. For example, hostile duelers often cannot abandon a pattern for fear of loss of face, status, or property.

Paradoxically, a limited war may represent only a slightly improved form of con-

flict management. True, it is quantitative deescalation, but it is not a qualitative deescalation as a rule.

The psychological limitations of this method of social problem solving are qualitatively the same as those in total war. Threats to survival inevitably force contending parties to adopt the inexorable logic of defense and offense. The locked-in quality of the "win-lose" frame of mind strangles efforts to find avenues for productive bargaining, and the cycle of dueling and mutual destruction remains essentially unchanged.

II. *Mutual Problem-Solving.* Modern so-called collective bargaining attempts to break a *qualitative* barrier in dueling behavior because it reflects a change in attitude and in the motivational bases for action. The legal requirement of negotiation in many modern conflicts has set the stage for mutual problem-solving leading to intelligent trading behavior. The special conditions for such an outcome involve not only a conscious effort to abandon open hostile dueling but the emergence of mutual trust. But we may ask, what in addition to mutual trust is the major difference between such problem-solving and the other patterns of conflict management? What can one expect to find in this pattern and not in the others? Initially, the motivational basis of conflict management has changed from mutual punishment to mutual reward wherein the cultivation of positive attitudes toward one another is seen as valuable and necessary in its own right.

Management of Threat and Anxiety

Control of threat and of increased anxiety is an initial qualitative difference in mutual problem-solving. Anxiety has not always been correctly interpreted. At times

it has been called an unnatural element in behavior, an interpretation formed no doubt from clinical observations of its dysfunctional aspects and their effect upon personality. Such a limited interpretation has evidently narrowed its usefulness, for it fails to acknowledge the genuinely natural function of anxiety.

In moderate quantities, anxiety is a very effective energizer and motivator. As it increases, however, it tends to destroy the capacity to reason efficiently and thereafter acts to inhibit flexible, creative thinking, replacing it with impulsive flight or fight behavior.

This is why excessive threat is a potent negative force in conflict management, and may limit one's capacity to use effectively the bargaining strategies available. The indiscriminate use of threat is dangerous at best. There are many forms of it, and no matter how eloquently it is expressed, one can never be sure just *how much* anxiety and impulsive behavior a given form will produce in an adversary.

Negotiation involving the core resources of a person, group, or organization is less likely to result in fruitful trading behavior because of its threatening nature.

The alternative to threat of any kind is that form of behavior which succeeds in reducing anxiety by providing evidence of positive concern for the survival of one's adversary.

Anxiety is a form of "noise" in human communication. In its loudest forms it will destroy listener and communicator effectiveness. Since bargaining and trading depend upon good feedback they will be affected adversely by the loss of it caused by defenses against anxiety. This, of course,

eventually will leave only blind conflict and further dueling as an alternative form of exchange.

Capacity for Taking Interpersonal Risks

A second qualitative difference is a willingness to take risks with other people, which is a basic element in trust. Interpersonal risk⁸ is a formulation which argues that people will withhold or give away personal influence and control over one another (share and exchange resources) only after an initial assessment by them of the amount of personal risk involved in such a relationship. The concept of interpersonal risk may be applied to the group or organization one may represent. When the capacity to take interpersonal risks is inhibited by too much anxiety, negotiation toward higher forms of agreement is circumvented.

Other Advances

One advance is positive face-to-face confrontation. Fruitful negotiation is impossible among human beings by remote control. People require the constant reassurance of others' intentions by personal contact.

Dueling confrontations, unfortunately, are often not fruitful for the several reasons already given. They are familiar today as extremist responses to frustration on our campuses and in our communities. Eventually, some form of rational bargaining and compromise is necessary among even the most hostile adversaries.

Another advance is to establish a policy of improving trust by reducing threat and, subsequently, the inevitable human responses of anxiety, frustration, hostility, and defensive behaviors of flight or fight

associated with threat and anxiety. A good treaty is one special form. Another is to examine freely and with candor mutual goals and all available paths to such goals. All parties require accurate information about areas of mutual gain and agreement, as well as areas of legitimate differences. Still another is deliberate disengagement from old patterns of language and thought. Language and other cultural patterns can be serious barriers to effective mutual problem-solving.

A Final Step: Avoid the Most Valued Commodities

The intellectual and material resources of any person, group, or organization are usually ranked in terms of their survival value. Accordingly, as one bargains with the most precious elements of any social system, the price of a trading exchange will naturally be higher than for less precious elements. A price may be too high to allow trading if the things to be exchanged are too precious. At such a point normal further trading may become a threat and a conflict. To press one's advantage may convert a free exchange into a "win-lose" situation. An adversary will, as we have seen, respond with defense or offense if his capacity to survive is threatened. Negotiation involving the *core resources* of a person, group, or organization is less likely to

result in fruitful trading behavior because of its threatening nature.

Should the strategy of conflict management one adopts initially begin at the periphery of a group's valued resources? Our knowledge of human behavior suggests it might best begin there. Where one stops in trading and negotiation is a pragmatic matter guided by one's awareness of natural human boundaries which eventually become known. They have often been called "territorial imperatives" indicating that they are functional borders and frontiers which are there to assure survival. Consequently, empathy toward others is decidedly a cornerstone in negotiation and bargaining.

The critical nature of modern social conflicts (war, race, labor-management, for example) in a densely populated, interdependent world requires a continuing reassessment of conditions and needs and increased effort in the search for an improved method for effective conflict management.

REFERENCES

1. Boulding, Kenneth, A pure theory of conflict applied to organizations, in, Kahn, Robert L. and Boulding, Elise, *Power and Conflict in Organizations*, New York: Basic Books, 1964.
2. Homans, George, Social behavior as exchange, *Amer. J. Sociol.*, 63:597-606, 1958.
3. Lundstedt, Sven, "Interpersonal Risk Theory," *J. of Psychology*, 62:9-10, 1966.

On Helping The Disadvantaged

On May 4, 1968, the Board of Directors of the National Association for Mental Health adopted a statement of policy with respect to the Association's activity in behalf of the disadvantaged. In brief, it committed the Association to giving special emphasis to the needs of the poor and other disadvantaged in all program areas.

It is obvious that it is considerably easier to adopt such a policy than to implement it. A number of reasons are apparent:

Most people don't know how to help those who are different from themselves. No white person in the United States has known the effect of discrimination because of skin color. In the same manner, affluent people, of whatever color, don't know or forget if they once knew, what it is to be poor. Thus, for one or both reasons, many well-meant efforts to help fail because the help was of little or no real benefit to the person helped. Too, the problem of poverty is so deep and complex that it sometimes seems completely hopeless—as if the problem of mental illness were not bad enough in the first place.

There is a tendency to confuse the aims of help—to try to make other people over in one's own image. There is no reason that an Indian or Mexican-American or Negro should give up his culture and take on the trappings of white middle class America in order to be rescued from poverty or discrimination. Yet, too often, ef-

forts at assistance are directed in this manner.

Such things can be overcome; but, there are other, more disturbing impediments.

Too often the helpers are patronizing—they make the person being helped so aware that he is being helped that he is held down or turned away by the very process of being helped; or proprietary—the helpers seek to own the people they are supposed to help.

Some people want to help others as a generalized group at a distance, yet are embarrassed or bothered by, or balk at, dealing specifically with individuals from that group.

Finally, there are those who climb on the bandwagon without ever intending to do much or keep finding new bandwagons. And, unhappily, there are those who either moralistically or selfishly don't want to see change.

These things are not limited to the mental health association. But they can defeat our expressed desire to give special help to the disadvantaged—and they can defeat us in achieving our broader goals with respect to mental illness. Nor is there any certainty that they will be overcome. It remains for each individual, and the group of which he is a part, consciously and deliberately to see to this.

Among the items enumerated in the Board's statement was a call for the presi-

dent to assemble a committee of advisors from among those most knowledgeable and involved in the areas of poverty and disadvantage to advise on implementation of the policy. This has been done.

The committee has proposed that, by appropriate by-law changes, at least 20% of all boards and communities of the Association, at all levels, be economically disadvantaged persons or members of minority

groups. It is anticipated that this recommendation will be submitted to the membership at the Association's Annual Meeting in November, 1970.

Whether or not the proposal, as presented, or in some modified form, is adopted, or is an appropriate means of implementation of the policy with respect to the disadvantaged, the policy itself and the commitment it contains will remain.

JAMES E. CHAPMAN

NAMH ANNUAL MEETING

Focus—Prevention

Los Angeles, November 16-21, 1970

Opening session 5 pm Nov. 18

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MENTAL HEALTH ASSOCIATION

NAMH Position Statements on Family Life and Sex Education and Marriage Counselors

The following position statements, written by the NAMH Professional Advisory Council, were adopted by the NAMH Board of Directors on June 20, 1970.

FAMILY LIFE AND SEX EDUCATION

The Mental health implications of family life and sex education programs are self evident. Examination of the current scene as it affects young people, parents and families as well as the community at large, with all its attendant suffering, leaves little doubt about the need for responsible, relevant and effective education programs in family life and sex education. Indeed, it is one of the most practical mental health issues upon which a position can be taken. In supporting such, NAMH joins an impressive list of major educational, religious, medical and health organizations throughout the country who are endorsing responsible family life and sex education.

The increasing controversy surrounding the introduction of family life and sex education programs in public schools has extended itself to a degree where it poses a serious threat to this essential aspect in the health education of children and young people. Responsible programs directed towards improving knowledge about this critical phase of human development as well as bettering understanding between young people and their peers, young people and adults, are being subjected to strong opposition stemming from a variety of sources.

The primary source of family life and sex education should be in the home. For a variety of reasons, evidence indicates that

in many, if not most instances, children do not receive this type of essential information given in a comfortable, accurate and relevant form by their parents. Presentation of this essential component of health education under public educational auspices requires especially the participation (i.e. sanction) of parents not only to endorse such programs, but also to share in the matter of material to be presented, when and how such will be carried out and who shall teach the matter. Family life and sex education programs without this essential contribution of joint participation by parents and educators are subject to misunderstanding, suspicion, attack, and early failure.

In addition to the parent role and effective pedagogical techniques including special teachers, family life and sex information programs require the support of a variety of helping agencies and individuals. Mental health organizations with their awareness as to the importance of these matters have an unusual opportunity to support and aid in the direction of family life and sex education programs in cooperation with other appropriate groups. A considerable number of national, state and local organizations have developed program materials or actual programs which may be useful to local mental health associations in their role as a resource group

to a community's effort to develop an appropriate program in family life and sex education.

It is recommended by the NAMH Professional Advisory Council that the local professional advisory committee of the mental health association be consulted when the Association considers programming in this field.

REFERENCES

Sex Information and Education Council of the U.S.
1855 Broadway, New York, N.Y. 10023

Guidelines for Developing School Programs in Sex Education

New Jersey Department of Education
225 West State Street, Trenton, N.J. 08624

Family Life and Sex Education Course Outlines
for Grades Seven Through Twelve
Anaheim Union High School District
1765 West Cerritos Street
Anaheim, California 92805

American Medical Association
535 North Dearborn Street, Chicago, Illinois 60610

Family Service Association of America
44 East 23rd Street, New York, N.Y. 10010

Family Life Literature and Films—an annotated bibliography
Minnesota Council on Family Relations
1219 University Avenue, S.E., Minneapolis, Minnesota 55414

STATEMENT ON MARRIAGE COUNSELORS

With the current state of knowledge, it is difficult to be definite as to the qualifications for marriage counselors. Far more research is needed to learn what constitutes effective intervention and to identify what skills are necessary to that process.

We do know that serious marital disharmony often gives rise to or is symptomatic of significant emotional upset. This clearly indicates that the person providing formal marriage counseling should be related to a broader system of mental health care.

We are also strongly persuaded that it is premature to think of marriage counseling as a separate profession or discipline. The issue of whether a person is qualified to deal with the emotional crisis of marital discord begins with whether the person has been trained to intervene in emotional crises in the first place. One is not a marriage counselor *per se*.

The qualifications for marriage counseling, as currently described by the American Association of Marriage Counselors, seem to us to provide a reasonable test of whether

a person might be equipped to provide marriage counseling. That organization holds that counselors should, in the first place, be fully qualified to practice the profession in which they achieved their original graduate training. A minimum of a Master's degree in social work, an M.D., or Ph.D. in psychology, sociology or a closely related field, a B.D. or other recognized three-year graduate degree from a theological seminary is required. For such persons, an additional year of clinical internship followed by a period of three years of professional practice is recommended.

For those wishing additional information, we attach a background paper used by the Professional Advisory Council in developing this statement. (*Available on request*)

It is recommended by the NAMH Professional Advisory Council that the local professional advisory committee of the Mental Health Association be consulted when the Mental Health Association enters into discussion about the issue or into any form of local evaluation and action.

Book Reviews

A Time to Heal: Corrective Socialization—A Treatment Approach to Childhood Schizophrenia

By William Goldfarb, M.D., Ph.D., Irving Mintz, M.S.W. and Katherine W. Stroock, A.B.

New York, International Universities Press, 1969. 148 pp.; \$5.

There are perhaps few areas of clinical concern that are more clouded by conflicting theories of etiology, course and treatment than that of childhood schizophrenia. Since 1953, the Ittleson Center for Child Research has been engaged in research and treatment of children designated as schizophrenic. In *A Time to Heal*, Dr. William Goldfarb, director of the Center, Irving Mintz and Katherine Stroock present their views on the educational correction of the functional deficits shown by these children. In their view, the objective of treatment is to stimulate the growth of absent or deficient function by constantly exposing the child to a series of sensitively handled experiences. The authors reject the view that "therapy" can be provided to the child once, twice or five times a week, in relatively brief encounters, and yet be effective. Rather, their aim is to provide a total milieu where the child is responded to with an active remedial attitude and with corrective experiences.

At the Center the children are treated by child care workers, teachers and their psychiatrists. In the major portion of the book, the treatment approach of the Center is presented by providing case illustrations followed by comment on the significance of the interaction between the worker and the child.

I must admit that I approached this book with considerable bias, having been trained largely from a learning theory point of view, and finished by being rather impressed by the straightforward commonsensical approach of most of the treatment.

For example, children who express fear of a counselor's departure are reassured and a child who is afraid of the fire in the boiler is told by her teacher, "Don't worry, I won't let the fire

hurt you", as she places herself between the fire and the child.

These and other such examples of common sense handling of aberrant behavior are refreshing when compared with Melanie Kleinian psychoanalysis, but rather commonplace for anyone who has worked with experienced special educators or nursery school teachers. Yet the authors suggest that it is only by understanding the psychoanalytic significance of the child's problems that corrective socialization can occur. The girl who was afraid of the boiler is said in truth to identify the boiler symbolically as her father, (why not her mother?) and fears the fire because of the sexual excitement she feels towards him. In my view, such speculative interpretation may fortuitously, or not, result in the proper action being taken, but may also inhibit teachers from acting in a common sense, spontaneous and direct manner.

As I read the psychoanalytic commentary I could not help thinking how easily the examples of corrective socialization could be interpreted equally with learning theory jargon. This, despite the author's criticism of "programmed schedules of reinforcement". For example, "One must respond to "normal" communications with interest (reinforcement)*, whereas symbolic and illogical productions are to be met with indifference (non-reinforcement) and, eventually, the withdrawal of shared pleasures (contingent consequences, punishment, etc.). With patience, and confidence in the rightness of the procedure on the part of the therapist, even a very bizarre child can move toward a more logical verbal communication and toward more socially acceptable behavior".

While I found many other little things in the book distracting, on the whole, it is worthwhile. Its lack of a statement of generalizable principles for working with severely disturbed children will restrict its use for mental health professionals. However, its presentation of sensitively and practically handled situations with the disturbed child, may prove interesting to nurses, child care workers and students of special education.

MARTIN GITTELMAN, PH.D.
New York, N.Y.

* (The bracketed comments are my own.)

The Encyclopedia of Human Behavior: Psychology, Psychiatry, and Mental Health

By Robert M. Goldenson, Ph.D.

New York, Doubleday & Co., 1970. 1,472 pp.; \$19.95.

One of the notable gaps in the education of both the general educated public and the youngster beginning to be interested in the behavioral sciences as a career, has been the lack of a comprehensible introductory guide. Young people—among the most gifted, too—like to browse for a while in a field that has begun to interest them. Browsing in the field of human behavior, until one has achieved a certain level of sophistication, is a difficult undertaking. One may ingest a good deal of nettles, Jimson-weed and sundry other indigestibles as well as more solid fare.

Now Dr. Goldenson comes along to remedy this situation and has succeeded beyond any reasonable expectation. Probably not since Tuke's remarkable work of 70 or 80 years ago have we had anything quite like it. It is what the French would call a triumph of *haute vulgarisation*. Here is a remarkably broad coverage of those areas of human behavior which preoccupy the behavioral scientist at the present time, presented in a pleasant and unobtrusive prose.

The author has been kind enough to thank the reviewer for some tiny service he rendered during the book's gestation, but my gratitude does not, I think, sway me by itself in the direction of approval. If I were looking at the articles contained herein from the viewpoint of a professional, I am sure that I would fairly often find areas within my own competence, that are rendered as somewhat simpler than reality. However, if I put myself back in time to the period at which I was wondering about a career in psychiatry, these volumes would have been a remarkable pleasure to come upon. The reader whose needs lie in obtaining simple but accurate information about complex and jargon-filled subjects, has no better resource at his disposal. It is not, of course, by itself a major resource for the professional but I suspect that many of us will consult it surreptitiously in order to find out what on earth *Time* magazine

is talking about in its latest column on behavior. It might keep us a step in advance of our increasingly well-informed patients.

I am rather sure—this takes no great prophetic skill—that some professionals will review these volumes in a highly negative way; but they will miss the point. The point is that we have badly needed for a long time a *good* summary of modern theory and practice suitable for the layman and the beginner. I think we have it now. I think most mental health associations would find this a useful addition to their libraries. So, too, would school libraries at every level.

DONALD P. KENEFICK, M.D.
Dean, New York School
of Psychiatry

Everything You Always Wanted To Know About Sex (but were afraid to ask)

By David R. Reuben, M.D.

New York, David McKay Co., Inc., 1969. 342 pp.; \$6.95.

It had to happen sooner or later, the *Everyman's Guide to Sex*. Perhaps only a California psychiatrist could have produced this highly readable, entertaining volume that tells you everything you would want to know and more.

The author has a non-judgmental, folksy approach to every conceivable (no pun intended) problem, although he does reserve the usual psychoanalytic "sick" label for homosexuals and will undoubtedly be on the Gay Liberation blacklist for some time to come.

It's possible to quibble over a few facts, and many reviewers have, especially in the area of homosexuality. But, much of the information is sound. If the basic information could only be relayed to those who so bitterly oppose sex education, Dr. Reuben will have performed a lasting service.

JOHN DORAN, M.A.
Philadelphia, Pa.

BOOKS RECEIVED

Because of space and time limitations, we cannot review all the books we receive. The listing of such books in this column must be considered acknowledgment of the receipt of the volumes indicated. As space, time and subject matter permit, we will publish full-dress reviews of the more significant books on the areas of interest of our readers.

BEHAVIORISM. By John B. Watson. New York, W. W. Norton & Co., Inc., 1970. 308 pp.; \$1.95, paperback. Yes, this is the classic work, now in a handy paperback edition.

CHANGING HOMOSEXUALITY IN THE MALE. By Lawrence J. Hatterer, M.D. McGraw-Hill Book Co., 1970. 492 pp.; \$15. Case histories, transcripts of therapy sessions and explanations of treatment methods make up this book. Dr. Hatterer draws on experience in treating more than two hundred homosexuals over the last seventeen years.

CLIENTS OR CONSTITUENTS. By Neil Gilbert, Ph.D. San Francisco, Jossey-Bass, Inc., 1970. 192 pp.; \$7.75. The author analyzes an anti-poverty program in Pittsburgh to determine the dynamics involved in increasing the influence of poor people upon the institutions that serve them.

THE COMMON BASE OF SOCIAL WORK PRACTICE. By Harriett M. Bartlett, with the assistance of Beatrice N. Saunders. New York, National Association of Social Workers, 1970. 224 pp.; \$4, paperback. This is an overview of social workers' ways of thinking about their practice.

THE DESIGN WITHIN: PSYCHOANALYTIC APPROACHES TO SHAKESPEARE. By M. D. Faber. New York, Science House, 1970. 551 pp.; \$13.50. The author has gathered essays on the psychology of Shakespeare's works (three by Freud) and added his own evaluations of them.

DYNAMIC PSYCHIATRY IN SIMPLE TERMS. By Robert R. Mezer, M.D. New York, Springer Publishing Co., Inc., 1970. 179 pp.; \$3.50, paperback. Readable textbook, now in its fourth edition, revised to reflect the changes in nomenclature of the Diagnostic and Statistical Manual of Mental Disorders.

EXPERIENCING YOUTH: FIRST PERSON ACCOUNTS. By George W. Goethals and Dennis S. Klos. Boston, Little, Brown and Co., 1970. 399 pp. paperback. This book presents cases, written by young people, that illustrate aspects of the psychology of adolescence.

HEALTH IN THE MEXICAN-AMERICAN CULTURE. By Margaret Clark. Berkeley, University of California Press, 1970. 253 pp.; \$2.45, paperback. Even though

it is a second edition of a study first published ten years ago, the problems of health care have not changed much.

HELP ME! By Lu Etta C. Al-Saadi, M.S.W. and Dorothy Goos, M.S.W. Kaukana, Wisconsin, Thomas Publications Ltd., 1970. 383 pp.; \$18.75. Group living therapy approach to helping adolescents.

HOW TO LIVE WITH YOUR SPECIAL CHILD. By George von Hilsheimer. Washington, D.C., 1970. 272 pp.; \$7.50. Using behavior therapy, Rev. von Hilsheimer has set up a residential school for difficult children. He discusses his theories of education and administration.

INCENTIVES TO WORK. By David Macarov, Ph.D. San Francisco, Jossey-Bass, Inc., 1970. 253 pp.; \$8.75. Why has the richest country in the world been unable to wipe out poverty? The author suggests that it is our fear that providing the poor with a decent living will ruin their incentive to work, thereby allowing them to do what many of the nonpoor secretly wish to do—live a life of leisure. Dr. Macarov examines the American attitude toward work and disproves the theory that men will stop working if given unearned income.

NEW UNDERSTANDINGS OF HUMAN BEHAVIOR. Edited by Harold D. Werner, M.S.W. New York, Association Press, 1970. 286 pp.; \$7.95. Billed as a "frontal attack on the Freudian and neo-Freudian Establishment", this is a collection of articles from professional journals that span the period 1960-68.

PET-ORIENTED CHILD PSYCHOTHERAPY. By Boris M. Levinson, Ph.D. Springfield, Illinois, Charles C Thomas, 1969. 202 pp.; \$9.75. Even those who aren't interested in the use of pets with emotionally disturbed children will enjoy reading about the psychology of animals and of man's involvement with them.

THE PREVENTION OF DRINKING PROBLEMS. By Rupert Wilkinson. New York, Oxford University Press, 1970. 301 pp.; \$10. This book grew out of the work of the Cooperative Commission on the Study of Alcoholism. It outlines methods to influence the "climate" of drinking, which, Wilkinson believes, is a powerful factor behind problem drinking.

THE PSYCHIATRIST AND PUBLIC ISSUES. Formulated by

the Committee on International Relations, Group for the Advancement of Psychiatry. New York. GAP Publication No. 74, 1969. 25 pp.; \$1. Outlines basic considerations that a psychiatrist must take into account when he becomes involved in public issues, both personally and professionally.

THE PSYCHOLOGICAL ASSESSMENT OF CHILDREN. By James O. Palmer, Ph.D. New York, John Wiley & Sons, Inc., 1970. 475 pp.; \$12.50. Textbook for the clinician.

PSYCHOTHERAPY AND THE DUAL RESEARCH TRADITION. Formulated by the Committee on Therapy, Group for the Advancement of Psychiatry. New York,

GAP Publication No. 75. Examines the conflicts that arise within the field of research.

SEX IN THE CHILDHOOD YEARS. Edited by Isadore Rubin, Ph.D. and Lester A. Kirkendall, Ph.D. New York, Association Press, \$4.95. A collection of articles on all aspects of sex education for children. Written for parents, teachers and counselors.

TWO CHILDREN BY CHOICE: The Why and How of the Two Child Family. Isadore Rossman, M.D. New York, Parents' Magazine Press, 1970. 151 pp.; \$3.95. In praise of voluntary family planning, this book discusses all aspects of the decision to limit one's family.

Film Reviews

Hospital (90 min., black and white, 1969) Produced by Frederick Wiseman. Distributed by Osti Films, 264 Third, Cambridge, Massachusetts 02142.

A documentary look at New York's Metropolitan Hospital becomes a commentary on some of the overpowering problems of society in Frederick Wiseman's latest film "Hospital". No commentator breaks the reality of the misery, fear and worry that weigh on the patients and staff; the only sounds are those recorded live by microphones at the scene.

Although filmed at a general hospital and depicting the problems and frustrations of general medical care to the poor, aged and others rejected by society, it goes much deeper than a mere comment on delivery of health services. It gives a penetrating view of many of society's wrongs. It vividly presents a society that forces a man to fear for his unattended children rather than for his health, a society that can find no place for a neglected child who has been left to the care of an alcoholic grandmother, a society that cannot provide welfare for a young, schizophrenic homosexual in order that he might financially afford to give up prostitution.

If Wiseman is cruel to society, he is the opposite to the medical professionals. He shows them as efficient and sensitive workers being forced to work under unbelievable conditions and make decisions no human being should be called upon to make.

"Hospital" has been shown on educational

television for general audience viewing. It could also be shown to specific audiences to sensitize them to the problems in delivering health services to the poor, on the one hand, and the problems of society that must be corrected before all citizens are allowed the right, to good health, on the other.

Boys in Conflict (72 min., black and white, 1969) Produced by Dr. Edward A. Mason, Department of Psychiatry, Harvard Medical School. Distributed by Center for Mass Communication of Columbia University Press, 440 West 110th Street, New York, N.Y. 10025.

Camp Wediko in New Hampshire provides a unique living and learning experience for emotionally disturbed boys. This film was shot at the camp during a seven-week period and shows the development of both campers and counselors during that time. The main focus is on one counselor, Steve, and his cabin of nine boys. As the campers follow Steve, the viewers experience a "working through" of problems as they arise. Steve discusses many of his actions with other counselors and with professional staff in an attempt to understand the boys he is working with and to better understand himself.

The film is an excellent training film for staff working with emotionally disturbed children. It does not attempt to provide a documentation of an ideal treatment milieu; rather, it is one interesting and provocative glimpse of one means of treatment.

Pam Wilson, M.A.
Washington, D.C.

MENTAL HYGIENE

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Violence and the Mentally Ill

(Free on request from NAMH, 10 Columbus Circle,
New York, N.Y. 10019)

New and revised pamphlets:

Clergy: Clergyman's Guide to Recognizing Serious Mental Illness—Single copy free. \$6.50 per C
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Insurance in Modern Mental Health Care—Single copy free. \$3.50 per C

The current thinking concerning insurance coverage for mental illness.

Mental Health Manpower Kit—\$2.50 per kit

Contains the NAMH Statement on Manpower and 34 features mental health manpower programs covering examples of new

careers, new sources of workers (among them the disadvantaged) and innovative uses of volunteers. Can be used as a resource in developing new mental health manpower programs for universities, junior colleges, hospitals, clinics, community mental health centers, professional organizations and local mental health associations.

Mental Illness: A Guide for the Family (revised edition)—1-24 copies 50¢ each; 25th copy and all additional copies—35¢ each

Handbook for families of the mentally ill
NAMH Publications Catalog—free.

Pierre The Pelican Series—Single set \$1.00. \$25.00 per M without imprint. \$30.00 per M with imprint
A series of 28 pamphlets on child care for first-time parents

Joint Information Service Publications

(Bulk orders available from Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington, D.C. 20009. Discount for bulk orders.) The Joint Information Service is sponsored by the National Association for Mental Health and the American Psychiatric Association.

Approaches to the Care of Long-Term Mental Patients—\$2.50 each.

General Hospital Psychiatric Units: A National Survey—\$1.50 each.

Health Insurance for Mental Illness—\$2.50 each.

Partial Hospitalization for the Mentally Ill: A Study of Programs and Problems—(cloth) \$6.00 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

Private Psychiatric Hospitals: A National Survey—\$1.50 each.

The Community Mental Health Center: An Analysis of Existing Models—\$3.00 each. 5 or more copies \$2.50 each.

The Community Mental Health Center: An Interim Appraisal—(cloth) \$6.50 each. 4 or more copies \$5.25 each. (paper) \$4.00 each. 4 or more copies \$3.50 each.

The Psychiatric Emergency: A Study of Patterns of Service, 1966—\$2.50 each. 5 or more copies \$2.00 each.

The Treatment of Alcoholism—\$3.00 each.

Legal Services and Community Mental Health Centers, Henry Weihofen, \$2.00 each.

The Staff of the Mental Health Center: A field study—\$6.00 (hardcover), 4-9 copies \$5.25, 10 or more copies \$4.75.

The Mentally Ill Offender: A Survey of Treatment Programs, Patricia K. Scheidemandel and Charles K. Kanno, \$2.00 each.

Reprints from MENTAL HYGIENE
(Write NAMH, 10 Columbus Circle, New
York, N.Y. 10019)

Changing Concepts: Care and Caregivers; Matarazzo, Albee, Arnhoff, Bettis; Vol. 52, No. 2, 1968. 25¢

Cigar Box to Personality Box—art “therapy” in junior high school; DeLara; Vol. 52, No. 4, 1968. 15¢

The Citizen and Mental Health (includes list below); Vol. 50, No. 4, 1966. 35¢

The Citizen and Research; Kenefick
Citizens in Mental Health—What Are They For?; Ryan
The State Hospital in the “Bold New Approach” to Care of the Mentally Ill; Seale, Fryer, Easterling
The Clinic and the Community; Simmons
A Look into the Future of Psychiatry; Kubie

Developing an Inner City Mental Health Association; Bower and Elam; Vol. 54, No. 2, 1970. 15¢
Law, Society and Mental Illness (includes list below); Vol. 54, No. 1, 1970. \$1

Community Mental Health and the Criminal Justice System, Shah
Development of Community Mental Health Programs in the Civil Area
Tuticut Follies revisited: A Long Range Plan for the Mentally Disordered Offender in Massachusetts, McGarry
New York's Mental Hygiene Law—A Preliminary Evaluation, Zitrin, Herman and Kumazaka
Who is Competent to Make a Will?, Weihofen and Usdin
A Radical View of Social Welfare and Mental Health, Ginsberg

Manpower and Training; Matarazzo and Cowne; Vol. 54:3, 1970. 25¢

A Mental Health Curriculum for the Lower Grades; Lombardo; Vol. 52, No. 4, 1968. 50¢

Mental Health Manpower (includes list below); Vol. 53, No. 2 1969. 25¢.

Some Additional Perspectives on Mental Health Manpower; The Mental Health Manpower Dilemma; Bettis and Roberts
Approaches to the Mental Health Manpower Problem. A Review of the Literature; Cowne

The Psychiatric Patient and the State Vocational Rehabilitation Agency: A Nationwide Survey of State Agency Practices; Wolfe, Havens, Jenks; Vol. 47, No. 4, 1963. 15¢

Research in Mental Health: Results Obtained and Plans for the Future; Malamud; Vol. 43, No. 2, 1959. 15¢

From Sitter to Citizen: A Project of Vocational and Social Rehabilitation; Isaacson; Vol. 42, No. 4, 1958. 15¢

Schizophrenia—Breakdown in individuals at high risk for schizophrenia: possible predispositional perinatal factors; Mednick; Vol. 54, No. 1, 25¢.

A preliminary report of a long range study partially financed by the NAMH. The investigators found a distinctive premorbid pattern of behavior in a group of adolescents who suffered psychiatric breakdown. This pattern was found to be closely associated with pregnancy and birth complications which could have produced anoxic states likely to damage certain areas of the brain.

Social Action for Mental Health; Levinson; Vol. 41, No. 3, 1957. 15¢

Teaching for Personal Growth: An Introduction to New Materials; Borton; Vol. 53, No. 4, 1969. 15¢

Notice to Subscribers

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THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a co-ordinated citizens' organization working for the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis, and treatment of mental illnesses and handicaps, and for the promotion of mental health.

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